Medical malpractice insurance in Missouri

the current difficulties in perspective

an analysis
by the Missouri Department of Insurance

Scott B. Lakin, Director

February 2003

Table of Contents

Medical malpractice in Missouri:

the current difficulties in perspective

Executive summary

Missouri is enduring its third underwriting cycle in medical malpractice insurance in the past three decades.

After a decade of declining premiums and aggressive competition for market share, several large carriers – which underpriced their products, but accustomed providers to less expensive coverage – have withdrawn from the market nationally or become insolvent. Medical providers, particularly physicians, have experienced severe "rate shock" as they seek coverage from the remaining higher-cost insurers, which in turn are raising rates further. The withdrawal of carriers also has produced a serious capacity problem in which remaining malpractice insurers sometimes lack both the capital and underwriting staff to handle the demand for new business.

Just as in the previous two underwriting cycles, medical groups joined by many insurers and members of the business community have called for limits on malpractice liability awards to patients who have suffered major injury from medical negligence. Unlike most states, Missouri in 1986 adopted limits on an injured patient's ability to recover damages. Those changes appear to have added much stability to the Missouri malpractice environment:

- Claims closed and filed have trended downward for both physicians and other types of providers.
- In the past decade, awards for malpractice damages actually lagged behind general inflation.
- All increases in award sizes are accounted for by medical inflation, wage inflation (for lost earnings) and the increase in severity of the injury to the patient.
- Physicians pay less aggregate premium for malpractice coverage than in 1990, even though 40 percent more doctors are licensed. All medical providers also pay less overall for coverage than in 1990.
- Economic awards for increased medical costs and lost earnings now account for a greater share of total damages than non-economic damages.
- Missouri has few of the multimillion-dollar awards cited in the media and, when they do occur, most damages represent the medical costs to treat the injury and the income the victim cannot earn.

Insurers need time and capital to fill the void in the market left by the departed carriers. Physicians are hard-pressed to absorb increased malpractice insurance costs when they have limited ability to pass on those expenses to managed care companies and government programs. These difficulties, however, find their roots in the insurance underwriting cycle, not at the hands of the victims.

The experience of the past 15 years has provided valuable lessons on how to improve the administration of justice for medical negligence, which Missouri should adopt. But based on recent experience of other states — and previously in Missouri — **further "tort reforms" will not provide relief to financially distressed physicians for several years, if at all**.

Yet after creating a stable market that benefited providers over the past 15 years, Missouri should not allow that environment to deteriorate. The General Assembly should enact legislation to **reverse and clarify a recent court decision that threatens to weaken non-economic damage caps**, which would increase insurers' assessment of risk.

The Missouri Department of Insurance (MDI) also believes the state faces an imperative public safety need to assist the physician community during this transition until a "softer" market develops. MDI favors emergency legislation to allow a **joint underwriting association to provide coverage at fair rates to physicians in critical specialties** such as obstetrics, emergency and trauma medicine and surgery, who historically have faced the highest risks of malpractice litigation and the highest level of premiums. MDI anticipates that the JUA will only operate for a few years, but needs to begin offering coverage this year.

Considering the large increases for those who buy coverage in the private market, I have directed my staff to prepare for a formal examination of the state's major malpractice insurers. Missouri always has relied on the free market to police malpractice rates, and **we need a better understanding of whether Missouri's medical malpractice market remains competitive, how the carriers set rates and whether they are excessive or, in the 1990s, were inadequate**.

MDI also has been disappointed by the general absence of debate on the underlying cause for malpractice – preventable medical errors. During the 1990s, the insurance, business and labor communities worked with government to conquer a workers compensation price spiral by slashing workplace injury rates and unleashing market forces to reduce premiums by about 25 percent. Missouri should devote that same degree of intensity to improving **patient safety**.

The National Institute of Medicine's landmark report on medical errors in 1999 indicated that 44,000 to 98,000 Americans die in hospitals alone each year from preventable medical errors, translating into a prorated share of up to 2,000 Missourians. Many more suffer permanent injuries from errors in other medical settings. Cost pressures to reduce staffing while adopting expensive new technologies, increased reliance on medications, time pressures in a managed-care environment and other forces have fostered conditions that need to be addressed.

MDI urges Gov. Bob Holden to **convene a broad-based commission to recommend legislative, administrative and clinical measures to improve medical outcomes and prevent errors.** That sort of medicine will provide a long-term remedy for many of the ills that the malpractice market.

_____

Scott B. Lakin, Director
Missouri Department of Insurance
February 6, 2003

Summary of MDI recommendations for medical malpractice improvements

1. Missouri should establish a limited-scope **joint underwriting association to offer medical malpractice coverage for distressed specialties critical to the public safety**. An alternative -- a patient compensation or excess liability fund -- would spread responsibility for more expensive awards and should reduce premiums, but it likely would require all Missouri physicians to carry such coverage and take longer to establish.

2. The governor should immediately establish a **Missouri Commission on Patient Safety** to explore ways to reduce medical errors that drive the cost of malpractice and permanently disable and/or kill our residents.

3. The General Assembly should **reverse the effect of the Scott decision**, an appellate court ruling that allows multiple caps for non-economic damages when only one injury has occurred.

4. The General Assembly should require judges to **dismiss cases, without prejudice, in which plaintiff's attorneys have not produced affidavits attesting to malpractice** from qualified professionals within 90 days after the lawsuits are filed.

5. MDI will conduct a formal **multi-company examination** to determine **whether Missouri's medical malpractice market for physicians is competitive, how carriers calculate rates, the role Missouri loss experience plays in those calculations and whether Missouri rates now are excessive (or have been inadequate in the past)**.

6. A change in Missouri law should allow MDI to **reject malpractice rate filings that do not meet acceptable standards on using Missouri-only data.**

7. As soon as practical, Gov. Bob Holden should propose a **Medicaid reimbursement increase for obstetricians**, who deliver more than 40 percent of the state's newborns under this program. These high-risk physicians now have few ways of recouping increasing costs for medical malpractice.

8. Missouri should **prohibit insurers from surcharging providers that have a pending medical malpractice claim**.

9. The law should **give physicians and other medical malpractice policyholders at least 60 days notice of nonrenewals and renewal rates**.

10. MDI should begin collecting **data by medical specialty to monitor whether rates charged to specialists are reasonable and whether coverage is available**. MDI should also have the statutory authority to **fine self-insured providers that do not file data** as required by law.

11. MDI should work with insurers to develop **a plan for staggering the expiration dates of medical malpractice policies**, particularly for physicians, to avoid the logjam that has contributed to the failure of physicians to receive timely quotes on new policies.

Missouri's market: an overview

Key facts

- **Missouri – unlike half the states – already has a cap on non-economic damages, which compensate the victim for lost quality of life and incidental costs because of his/her injury. (pp. 33-35)**

Enacted in 1986, Missouri's cap started at $350,000. Adjusted annually by law with a U.S. Department of Commerce factor, the cap became $557,000 for 2003. In last year of available data, only six of 439 paid claims reached the cap. (p. 20)

- **Missouri does *not* require physicians to carry medical malpractice insurance unless they are on staff at urban hospitals. In that case, they must have $500,000 in coverage. (p. 45)**

- **For 15 years, claims filed and closed with payment – both key indicators — have trended downward for both physicians and other types of providers. (pp. 14-15)**

In 2001 – the last year of available data — the number of claims closed with payment dropped to 439, or by 42 percent from the peak of 1988. Claims filed have shown a similar decline. Since 1987 – the apex for filings – such claims overall fell from 2,244 to 1,599, or by 29 percent. Physicians have been less successful than hospitals in reducing claims frequency. Hospitals reduced their claims by 72 percent while claims against doctors dropped 22 percent over these 15 years.

- **In the past decade, awards for malpractice damages actually lagged behind general inflation. (p. 16)**

For all providers, the average payment on paid claims rose 15.5 percent between 1992 and 2001, compared to a general consumer price index (CPI) change of 26 percent. Average payments on claims closed against physicians rose 23 percent. Adjusted for inflation, claims payouts against physicians declined by 20 percent over the decade.

- **All increases in award sizes are accounted for by medical inflation, wage inflation (for lost earnings) and the increase in severity of the injury to the patient. (p. 18)**

Wages and health care – the main costs paid by medical malpractice damages — experienced inflation rates much greater than the CPI over the past decade. Severity of the injury sufferedalso increased dramatically, particularly after 1999. While the average injury had been graded **permanent and minor in 1987** when the system began, the severity rating by insurers themselves jumped **permanent and more than significant by early 2002**. (p. 17) These factors have played an important role in increasing compensation to victims.

- **Physicians pay less aggregate premium for malpractice coverage than in 1990, even though 40 percent more doctors are licensed. All medical providers also pay less overall for insurers' coverage than in 1990. (p. 29)**

All medical care providers paid $127 million for malpractice policies in 1990, compared to $97 million in 2001, a decline of 24 percent. Providers purchased another $22.2 million in the unregulated "surplus lines market" in 2001. Even without adjusting for inflation, premiums for all providers fell at least 5.5 percent. For physicians only, the malpractice bill in the

admitted market dropped to $68 million in 2001 from $94 million in 1990, or a reduction of 28 percent. (Premium figures in the surplus lines market are not available for physicians and surgeons in either 1990 nor 2001; self-insured facilities or corportions do not report. "Self-insured" doctors are a misnomer – they are uninsured.)

- **Most damages awarded in Missouri cover lost earnings and extra medical costs for treating the injury suffered by the victim. (p. 18)**

Since 1997, "pain and suffering" awards have been *less* than economic payments. In 2001, non-economic damages were 92 percent of the awards for health costs and lost wages after reaching a low of 80 percent in 1999. For the first six months of 2002, non-economic damages fell to 87.2 percent of the economic award.

- **Missouri has few of the multimillion-dollar awards cited in the media and, when they do occur, most damages represented the medical costs to treat the injury and the income the victim cannot earn. (p. 20)**

Missouri recorded 11 awards for $1 million or more in 1996, of which five were for $2 million or more. Those numbers since have trended *downward*. **Over the past five years, Missouri had 36 awards of more than $1 million, or 1.4 percent of all paid claims. Of those 36 awards, seven were for more than $2 million, or 0.2 percent of all paid claims.**

Recent market changes

- **Between August 2001 and May 2002, more than half the Missouri market – 57 percent — disappeared for doctors who were seeking new carriers. Only three carriers were taking new business, for all practical purposes. These remaining companies lacked the capacity – even simply the underwriting staff – to process applications and handle doctors' demand after the insolvencies and withdrawals. (pp. 25-26)**

During those nine months, two carriers (PHICO and Legion) became insolvent, two very large insurers (St. Paul and Chicago) withdrew from the national market and Missouri's largest company (Intermed) exhausted its financial capacity. Neither the insolvencies nor withdrawals were traced to problems in Missouri's market.

- **During the past three years, Missouri's four largest remaining writers have raised rates from 28 to 97 percent. (p. 30)**

- **Missouri's market for physicians remains attractive, although new entrants will need time to develop a distribution network. In the past few months, five companies have been licensed, decided to expand or applied for admission to Missouri. (p. 31)**

Early signs point to increasing interest from insurers in the Missouri market for physicians, which would increase capacity and spur price competition. The large Missouri Hospital Plan (the state's sole provider-controlled insurer, operated by the Missouri Hospital Association) plans to expand its offerings for physicians; in March it will offer coverage for physicians who are on staff at the hospitals rather than just the doctors directly employed by hospitals. Particularly this entry into the physicians market could increase price competition in the immediate future, depending on the scope of its expansion.

The basics of medical malpractice insurance

Medical malpractice lawsuits were filed in London in the 1600s, and Blackstone's Commentaries addressed medical negligence in England by 1803. American litigation dates back to colonial times.

These lawsuits grew more commonplace by the mid-1800s – and were welcomed by skilled medical doctors as a means to curtail the practices of others who had neither medical education nor government licenses. Instead, the development boomeranged as the best-trained and -qualified doctors were held to higher standards. Of particular concern then were compound fractures, whose treatment often resulted in shortened limbs.

By the late 1800s, medical malpractice insurance became available as protection for qualified physicians, but may also have had an unintended effect: doctors became worth suing when poor outcomes resulted unexpectedly, at least in urban areas.

Nevertheless, medical malpractice litigation was considered rare – often a news curiosity – until at least the 1960s. By then, growing rates of health insurance in a more middle-class America increased access to medical care, and numerous sources – from physicians themselves to research breakthroughs to television – heightened consumer expectations about outcomes.[1]

Poor outcomes, however, do not necessarily constitute medical malpractice. Not all patients respond the same to all treatments, and treatments aren't foolproof. If a patient has been advised about the risks and provides informed consent to standard medical procedures, no malpractice likely occurs despite an injury.

Black's Law Dictionary cites four elements that the patient must prove to establish a claim of malpractice:[2]

1) The existence of the physician's (or other health-care provider's) **duty** to the plaintiff, usually based on the existence of the physician-patient relationship.
2) **Negligence**, or violation of an applicable standard of care. These standards reflect training: a physician may be held to a higher standard of care than a nurse, and a specialist to a higher level yet. Standards of care may vary among geographic areas.
3) **Damages** (a compensable injury). A patient may suffer from negligence, but if no permanent damage results, the likelihood of malpractice is negligible.
4) **Causation**, or connection between the violation of the standard of care and the harm.

Expert witness testimony is necessary to prove, in particular, negligence and causation.

Malpractice insurance provides significant protection – often $1 million per occurrence and $3 million maximum – for providers and their personal and business assets. But this coverage also protects patients, their families and ultimately the government from extra medical expenses, lost income and decreased quality of life.

In Missouri and most jurisdictions, a plaintiff may receive an award in three parts:

- **Economic damages**, or the cost of medical treatment needed for the negligent injury and the loss of earnings that resulted. These damages account for the majority of awards in Missouri.
- **Non-economic damages**, which compensate the victim or family for loss in the quality of life from the injury. These damages may cover a patient's pain and suffering, loss of enjoyment of life, inability to engage in usual activities, emotional distress, disfigurement and mental anguish of survivors or disruption of family in wrongful death cases. Missouri is among half the states that limit the amount of such damages or total awards.
- **Punitive damages** against providers for willful misconduct. Such damages are strictly limited by Missouri law and rarely awarded; malpractice insurance does not cover these damages.

To protect personal assets against such awards and the cost of defending claims, physicians and other health-care providers typically buy one of two kinds of medical malpractice insurance:

- An **occurrence policy**, which typically has higher premiums, but longer coverage. Health-care providers are covered indefinitely for all incidents that occur between the first day and expiration date of the policy. These types of policies are no longer typical in Missouri.
- A **claims-made policy**, which only covers claims made while the policy is in effect for incidents during that period. These policies are initially less expensive than occurrence coverage, but increase over time. When a claims-made policy expires, the company may offer "tail" coverage to provide extended coverage for incidents that occurred while the policy was in effect, but for which claims have not been filed. "Tail" coverage can cost double or triple the original policy. If the provider does not purchase "tail" coverage, no insurance exists for any claim that is made after the expiration date, even though the injury occurred during the policy period. A provider may purchase "nose" coverage from a new insurer to provide protection for these past incidents, but such policies may be quite expensive.

Missouri doctors – unlike those in Kansas and many other states – are not required to carry medical malpractice insurance unless they have staff privileges at an urban hospital (located in a county with more than 75,000 residents).

In the spring of 2002, MDI Director Scott B. Lakin became aware of growing physician complaints about unexpectedly large premium increases, and he began meeting with groups of doctors around the state. Gov. Bob Holden asked him to hold a public hearing Oct. 30 and report on the growth of medical malpractice difficulties for physicians and other providers and the contrast with market conditions shown in MDI's annual malpractice report. This study responds to Gov. Holden's request.

Cyclical crises in medical malpractice insurance

Missouri's current medical malpractice difficulties are the third such development in the past 30 years. Each has been associated with insurance underwriting cycles and general economic downturns. Economists cannot explain the causes of these cycles of economic expansion and contraction. In essence, profitability creates competition, which leads to underpricing that breeds unprofitability and the flight of competitors from the market; then "hard" markets produce higher premiums and profitability that attracts new companies or encourages expansion, starting the cycle again.

In retrospect, the difficulties of the 1970s have been described as a "crisis of availability" – some providers, particularly doctors, could not find coverage at any price. The national literature indicates an increase in medical malpractice claims dating roughly from the late 1960s that resulted in withdrawal of the large, multi-line insurers that dominated the line. States like Massachusetts emerged with no such insurers still operating.

In the mid-1980s, the difficulties were more often considered a "crisis of affordability," in which rates for doctors and other providers were considered onerous.

The current medical malpractice market in Missouri bears the signs of the classic insurance underwriting cycle. A review of national analyses and a fall 2002 MDI survey of Missouri's medical malpractice carriers indicates that events dating as far back as the mid-1980s – during the last crisis – led to a hotly competitive market in the late 1990s in which several large carriers substantially underpriced their product. Even more conservatively priced carriers held rates low to maintain market share. This hyper-competition depressed pricing while wage increases and health care inflation naturally were forcing awards upward.

When several carriers withdrew from the market or became insolvent as true costs mounted, Missouri's physicians suffered from "rate shock" as they were forced to buy coverage from higher-priced insurers. Those carriers also were re-evaluating risks in a "hard" market, which led to further price increases. Physicians with adverse claims histories have severe difficulties finding coverage because the remaining carriers are more selective in their underwriting; these doctors may face significant new surcharges if their previous carriers did not take into account claims histories.

The question then becomes whether the remaining insurers in the market will raise rates to generate attractive profit levels. If so, eventually insurers offering coverage at significant savings likely will enter and expand in the market – beginning the cycle again.

The 1976 reforms

The crisis of the early and mid-1970s has not been well documented because the Missouri Department of Insurance did not collect detailed data during the era.

The Missouri General Assembly in 1976 responded to availability difficulties by enacting Senate Bill 471 (Sections 538.010 to 538.080, RSMo). A key feature established a **pre-trial screening mechanism for medical malpractice lawsuits** before a "professional liability review board," which was designed to encourage early settlements of malpractice cases, but not prohibit court action. The six-member boards were composed of a circuit judge who presided, two attorneys, two medical professionals (one of whom practiced the specialty of the defendant) and a lay member; the members changed from case to case.

With 90 days notice, the board convened to hear evidence on the case and could subpoena witnesses. Although hearings were informal, the testimony was sworn, and a formal record was kept. Within a month after the hearing, the board was to make its recommendations on liability and damages. A plaintiff who did not accept the recommendations still could proceed to trial, at which no mention of the board's action was permissible. Insurers paid a tax to fund the board's operation.

In February 1979, the Missouri Supreme Court struck down this procedure as an unconstitutional barrier for individuals to the courts. A state constitutional provision states that "the courts of justice shall be open to every person, and certain remedy afforded for every injury to person, property or character, and that right and justice shall be administered without sale, denial or delay." The legislature later repealed all the 1976 tort reforms in 1984.

Although the members of the court have changed, the constitutional provision and this legal precedent should give pause to advocates of another screening mechanism that is designed to prohibit the filing of frivolous lawsuits. MDI is aware of no screening mechanism that strictly prohibits access to the courts, and states like Nevada recently have abandoned their screening panels after insurers indicated they only increased legal costs.

In a more significant change, the medical malpractice troubles of the 1970s gave impetus to creation of medical malpractice insurers owned by their provider policyholders. While this development was expected to have a short lifespan, such mutuals and their descendants control a majority – almost three-fourths — of the national medical malpractice market today. Although many did become insolvent because laws on capitalization were relaxed to encourage their establishment, others prospered and eventually grew into publicly owned corporations.

The 1986 reforms

Another sharp rise in medical malpractice claims and pricing problems prompted the General Assembly to pass SB 663 in 1986 (Chapter 538, RSMo).

Overall claims peaked in 1986 with almost 2,100 filed against hospitals, doctors and other health-care providers, tripling from 695 in 1979.

Loss-ratios for the medical malpractice line reached 136 percent earlier, in 1984, largely on the strength of a 188.1 percent figure for hospitals. Physicians actually posted an all-time high of 131 percent in 1981. (These figures compare to 81 percent for the entire line and 61 percent for physicians in 2001.) In each instance, losses were more costly than combined premiums and investment income for insurers.

The 1986 legislation:

- Capped awards for **non-economic damages** at $350,000 *per occurrence*, adjusted annually by MDI to reflect inflation. In 1975, California had enacted its "MICRA" limit on medical malpractice non-economic damages at $250,000 without any increases for inflation, prompting Missouri and more than a dozen other states to eventually adopt similar limits. (Half the states still have no limits on damages.) In Missouri, the indexed limits were $547,000 in 2002; they rise to $557,000 in 2003.
- Limited **punitive damage** awards to cases involving "willful, wanton or malicious" misconduct. Punitive damages, however, are not covered by medical malpractice insurance and have no effect on rates. In Missouri, punitive damages are seldom awarded.
- Required itemization of awards for past economic and non-economic damages and future damages, such as continuing medical care. Any party could request payment of future damages of more than $100,000 in a **structured settlement** that would limit such costs. For example, the death of a plaintiff after 10 years could end payment of both medical and wage indemnity.
- Required that the plaintiff file an **affidavit** for each defendant from a health-care provider stating the case possessed merit. The court could – but was not required to – dismiss the lawsuit without prejudice if no such affidavit was filed. (This provision replaced the screening mechanism of 1976 to discourage the filing of frivolous cases.)
- Modified **liability rules** to make a defendant jointly liable only with other defendants whose fault was equal to or less than his or her own, based on the judge's or jury's award. Previously, courts could force defendants who had any level of liability to pay the entire award if the other defendant(s) could not.
- Allowed the Administrative Hearing Commission, which hears licensing actions against professionals, to impose immediate, temporary **license restrictions** against a potentially dangerous provider, subject to appeal.
- Required physicians on staff at a hospital in a county more than 75,000 residents to maintain at least $500,000 in medical malpractice insurance or lose staff privileges.
- Required hospitals and outpatient surgical centers to report disciplinary actions against practitioners to their state licensing boards within 15 days.
- Required insurers and self-insured health-care providers to report claims information at least quarterly to MDI, which forwards the information to licensing boards.

Since 1986, the legislature has adopted few changes in medical malpractice law. In 1997, Missouri's landmark HMO reform law removed the malpractice liability exemption for health maintenance organizations, which generally led them to require physicians in their networks to carry coverage $1 million per occurrence with a $3 million maximum.

Aftermath of the 1986 revisions

Claims and awards

The passage of the 1986 law coincided with the almost immediate brightening of the Missouri medical malpractice market. Key indicators on claims and payment activity peaked in 1987-88 or before and fell sharply before rebounding and stabilizing by 1992. In the past 15 years, the cost drivers associated with the 1986 crisis have not been surpassed.

In retrospect, however, loss ratios had peaked and headed downward before the General Assembly acted. This phenomenon was noted in states across the country, whether or not they limited damage awards, and has sparked debate on whether market improvements stemmed from the dynamics of the insurance cycle or tort changes.

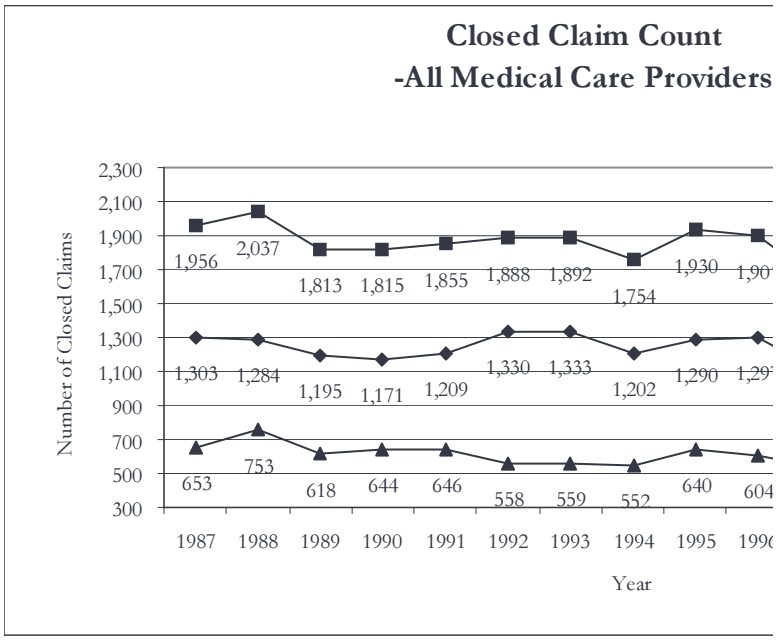
Profitability in Missouri became well established by 1988 when the line's loss ratio dropped to 45.6 percent – i.e., only 45.6 cents in benefits were paid or reserved of each $1 in premiums earned by insurers. Medical malpractice loss ratios in the lower to mid-50 percent range were the rule until 1999 when declining premiums helped raise the ratios. Physicians' coverage experienced much the same result: loss ratios dropped to 33 percent by 1990 before rebounding and remaining in the mid-60s through 2001, except for two anomalous years.

The 1986 changes, however, did not have an effect on premium costs for Missouri physicians for several years. MDI does not regulate rates, so its database contains little information on average premiums during the period. But from 1986 to 1989, total premiums continued climbing from $52 million to $94 million for physicians and from $94 million to $132 million for all medical providers. MDI released a report in September 1990 referring to companies that had begun reducing rates — a trend that continued for much of the following decade.

Missouri collects more detailed information on medical malpractice insurance than virtually any other state. Following is an analysis of the information submitted by insurance companies and self-insured health-care providers, as required by the 1986 statutes.

Claims activity

- **The number of medical malpractice claims closed with and without payment have declined markedly since the last reforms – by 37 and 42 percent, respectively, since the peak year of 1988, when pre-reform claims were still pending.**



These indicators reflect the recent past, combining claims filing activity in preceding years – medical malpractice claims take almost four years to settle on average – with the insurers' assessment of the prevailing legal climate, the facts of individual cases, their willingness to settle and any judicial result.

In the post-reform peak year of 1988, insurers closed 2,037 claims against all medical providers with payments on 753. By 2001, the number of claims closed had fallen to 1,288, or by 37 percent.[2] The number of claims closed with payment dropped to 439, or by 42 percent. Most of this decrease occurred during the six years since a secondary peak in 1995.

For physicians and surgeons, claims closed declined to 630 in 2001, or 41 percent from their peak year of 1990, when 1,061 claims were closed. Almost all the decline occurred since a secondary peak of 1,045 in 1995. Insurers and self-insureds paid out awards on 190 claims in both 2000 and 2001 for physicians.

As the first chart indicates, two-thirds – 66 percent – of claims closed in Missouri resulted in no payment in 2001; this ratio has remained steady for many years. The percentage rises among claims against physicians, in which the plaintiff prevailed in 20 to 30 percent of the claims from 1998 to 2001. This low percentage may be expected when torts are used to resolve medical negligence.[3]

- **Claims filed[4] – a key indicator of future system costs – have shown a similar decline. Since 1987 – the top year for filings – such claims overall fell from 2,244 to 1,599, or by 29 percent. Physicians have been less successful than hospitals in reducing claims frequency.**

Hospitals reduced their claims by 72 percent while claims against doctors dropped 22 percent over these 15 years.

Claims against doctors remained relatively stable from 1987 to 1996, when more than 1,000 still were filed against physicians. All of the doctors' declines have occurred since that secondary peak in 1996; the rate of filings has trended slightly upward over the past two years, growing from 736 in 1999 to 782 in 2000 to 815 in 2001, but remain 25 percent below the earlier peaks.

Malpractice awards and settlements

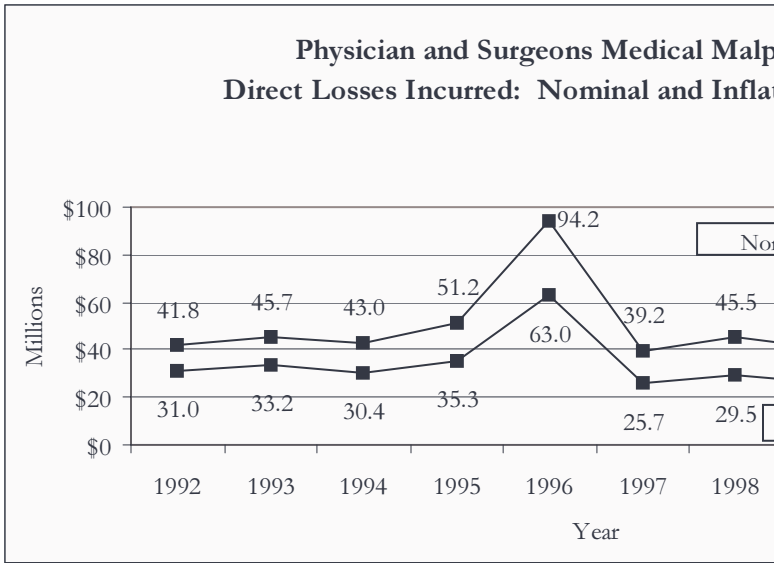
- **Since 1992, when medical malpractice insurance stabilized from the sharp peaks and troughs of the 1980s, the increase in payments to victims has lagged behind general price inflation in Missouri.**

For the entire line, **the average payment on closed claims with awards or settlements rose 15.5 percent between 1992 and 2001, compared to a consumer price index (CPI) change of 26 percent.**[5]

The average payment reached $165,859 in 2001 for claims closed (generally those filed about 1997), with $87,793 for economic losses and $81,066 for non-economic losses. Those figures compare to total average settlements of $146,148 in 1992, with economic damages of $64,276 and non-economic losses of $79,321.

Average payments on claims closed against physicians rose 23 percent, compared to the 26 percent CPI rise, posting an average of $202,358 for paid claims in 2001 with $118,441 for economic losses and $83,917 for non-economic losses. Those figures compared to $164,517 in 1992 when economic damages totaled $77,779 and non-economic awards were $86,737.

Total losses for physicians dropped considerably below 1992 when adjusted for inflation. When using the standard inflation calculators (based on 1982-4 prices in St. Louis), losses for physicians dropped from $31 million in 1992 to $24.8 million in 2001, or by 20 percent over the decade.



Standard inflation adjustment reduces the losses to 1984 dollars in St. Louis.

That malpractice payments have declined from 1992 levels, after considering general inflation, becomes even more surprising when considering that health-care inflation and wage increases, the drivers for economic damages, increased at even higher levels than the consumer price index (CPI). The change in malpractice payments compares, for example, to the effect of health-care inflation on HMO premiums, which rose 47.9 percent between 1998 and 2001.

- **The inflation-adjusted decline of these payments since 1992 also occurred even though the severity of injuries to the patient has risen substantially.**

When claims are filed, insurers assign a rating to describe the severity of the injury. According to the standard table used by insurers in their MDI reports:

- 1 = Temporary, Emotional
- 2 = Temporary, Insignificant: Lacerations, contusions, minor scars, rash.
- 3 = Temporary, Minor: Infections, mis-set fracture, fall in hospital.
- 4 = Temporary, Major: Burns, surgical material left, drug side-effect, brain damage.
- 5 = Permanent, Minor: Loss of fingers, loss or damage to organs, other non-disabling injuries
- 6 = Permanent, Significant: Deafness, loss of limb, loss of eye, loss of one kidney or lung
- 7 = Permanent, Major: Paraplegia, blindness, loss of two limbs, brain damage
- 8 = Permanent, Grave: Quadriplegia, severe brain damage, lifelong care or fatal diagnosis
- 9 = Death

Particularly since 1999, the severity has spiked, based on the assessment by insurers.

In 1988, the average injury suffered in closed claims with payment was rated about 5, or *minor* and permanent. However, by the first half of 2002, the average reached 6.2, or permanent and *more than significant* by the account of the insurers themselves. Most of this increase occurred after 1999, when the severity rating was 5.3.

The claims closed *without* payment had climbed to 5.5 by the first half of 2002, or more severe that the average *paid* claim in 1999 or 2000.

Average Claims Payment by Injury Severity

Injury Severity	1997	1998	1999	2000	2001
1	$37,061	$71,259	$43,155	$47,970	$49,903
2	$24,624	$16,654	$20,467	$20,539	$15,837
3	$40,153	$42,177	$52,836	$71,545	$45,439
4	$71,816	$95,416	$69,153	$125,179	$124,399
5	$149,759	$119,488	$92,693	$142,521	$90,250
6	$197,874	$185,503	$193,894	$299,576	$261,062
7	$380,485	$607,444	$430,899	$480,383	$530,262
8	$705,577	$369,414	$401,038	$576,477	$228,524
9	$199,594	$210,623	$152,697	$210,311	$198,651

Source: Missouri Department of Insurance medical malpractice claims data

The upsurge in severity may explain the signs of more expensive settlements and awards that then appeared in early 2002. During the first six months, average total awards jumped 28 percent, led by a 31 percent increase in economic damages for health costs and lost wages. These six months may represent another anomaly, but the development bears close monitoring.

- **All of the increases in average medical malpractice payouts since 1990 are accounted for by increases in the medical cost of treating injury, the earnings lost by the victim and the severity of the injury suffered.**

Through the 1990s, both average wages and medical costs – the primary elements of economic damages — tended to rise more rapidly than the CPI and act as the principal drivers of total indemnity. Furthermore, awards and settlements for lost earnings and treatment costs in malpractice cases increased faster than general wage and health care inflation. From 1992 to 2001, wage inflation in malpractice settlements grew 316 percent, and those earning losses were 202 percent more than general wage inflation.

The remainder of increases in awards is primarily attributable to a steady rise in the severity of injuries from 4.99 to 5.73 between 1988 and 2001. Preliminary data for 2002 indicates a further increase to 6.2.

Statistical methods can remove or "control" for the effects of rising wages, medical inflation, and injury severity on claim costs.

Without increases in health care costs and average wages, and if injury severities remained constant, average payments would have decreased fairly significantly during the 1990s. See the statistical model.[6]

- **Economic awards -- for lost income and extra medical costs -- have grown to outweigh non-economic damages since Missouri adopted its reforms in 1986, although the two remain closely linked.**

In 1987, non-economic awards/settlements were 104 percent of the economic damages, but that ratio has declined, particularly since peaks in 1992 and 1996 when it reached 125 percent, based on claims reported closed to MDI.

Since 1997, "pain and suffering" awards have been *less* than economic payments. In 2001, non-economic damages were 92 percent of the awards for health costs and lost wages after reaching a low of 80 percent in 1999. For the first six months of 2002, non-economic damages fell to 87.2 percent of the economic award.

■ **Few – in fact, a declining number of – medical malpractice awards equal Missouri's indexed cap on non-economic damages.**

Medical Malpractice Closed Claims, 1986-2001

Claim year	Total closed claims	Number closed above $250,000 non-economic damages	Number reaching Missouri's non-economic cap	Missouri's non-economic cap (indexed)
1986	2,067	5	5	$350,000
1987	1,956	13	9	356,000
1988	2,037	13	5	373,000
1989	1,813	17	7	391,000
1990	1,815	28	12	401,000
1991	1,855	40	16	430,000
1992	1,888	42	23	446,000
1993	1,882	35	16	462,000
1994	1,754	36	9	474,000
1995	1,930	48	13	482,000
1996	1,901	54	18	492,000
1997	1,625	50	10	502,000
1998	1,624	38	11	513,000
1999	1,622	34	6	517,000
2000	1,534	50	9	528,000
2001	1,288	37	6	540,000

The number of claims reaching Missouri's cap peaked in 1992 and generally has dropped since to only a handful of cases each year. In virtually every year, the severity of the claims receiving judgments equal to the Missouri caps averages a 7 or 8 – permanent injury like quadriplegia, blindness, severe brain damage requiring lifetime care or a terminal diagnosis.

In 2001, only 1.4 percent of the total 439 Missouri claims closed with payment reached the cap, which was indexed to $540,000 at that time.

The $250,000 figure on non-economic damages represents the California MICRA limits, which proponents of tort changes have advocated in Missouri and nationwide. HR 4600, which passed the U.S. House in September 2002 but died in the Senate, would have set a national cap on non-economic damages of $250,000 as well – but would have left Missouri's indexed limits in place; the federal legislation would have imposed caps only on the majority of states that do not have any now. Only 37 Missouri settlements/awards, or 8.4 percent of closed claims with payment, exceeded the MICRA caps in Missouri in 2001.

As the table below indicates, capping Missouri settlements and awards for non-economic damages at $250,000 would reduce total payments (not premiums) by about 10 to 12 percent, perhaps less.

Damages by category paid and non-economic damages exceeding California's $250,000 cap

Missouri, 1987-2002

Year	Total indemnity	Economic damages	Non-economic damages	Non-economic damages exceeding $250,000	% of total damages	% of non-economic damages
1987	$41,003,366	$20,091,034	$20,910,332	$1,948,250	4.8%	9.3%
1988	$52,721,590	$28,506,973	$24,139,617	$1,535,604	2.9%	6.4%
1989	$43,916,237	$21,882,070	$22,034,167	$2,830,955	6.4%	12.8%
1990	$64,952,967	$35,459,578	$29,493,389	$5,734,258	8.8%	19.4%
1991	$81,124,089	$43,622,123	$37,501,966	$8,189,215	10.1%	21.8%
1992	$81,871,513	$36,438,356	$45,433,157	$16,081,915	19.6%	35.4%
1993	$81,828,491	$42,138,210	$39,690,281	$10,277,275	12.6%	25.9%
1994	$74,595,146	$35,011,950	$39,583,196	$8,993,080	12.1%	22.7%
1995	$83,436,964	$37,349,665	$46,087,299	$8,258,718	9.9%	17.9%
1996	$104,184,324	$51,083,198	$53,101,126	$16,995,293	16.3%	32.0%
1997	$87,582,188	$44,876,651	$42,705,537	$10,187,393	11.6%	23.9%
1998	$81,417,382	$41,930,389	$39,486,993	$12,028,266	14.8%	30.5%
1999	$72,383,291	$39,680,388	$32,702,903	$5,320,132	7.3%	16.3%
2000	$90,482,814	$48,405,403	$42,077,411	$9,833,787	10.9%	23.4%
2001	$82,227,206	$42,735,152	$39,492,054	$8,143,102	9.9%	20.6%
2002 (9 months)	$72,488,001	$38,723,764	$33,764,237	$8,611,140	11.9%	25.5%

- **Missourians received few multi-million dollar awards that have surfaced in other states and, when such awards are made, they largely cover economic damages – i.e., medical costs and lost earnings. Such awards peaked in 1996.**

Multimillion-dollar awards in Missouri

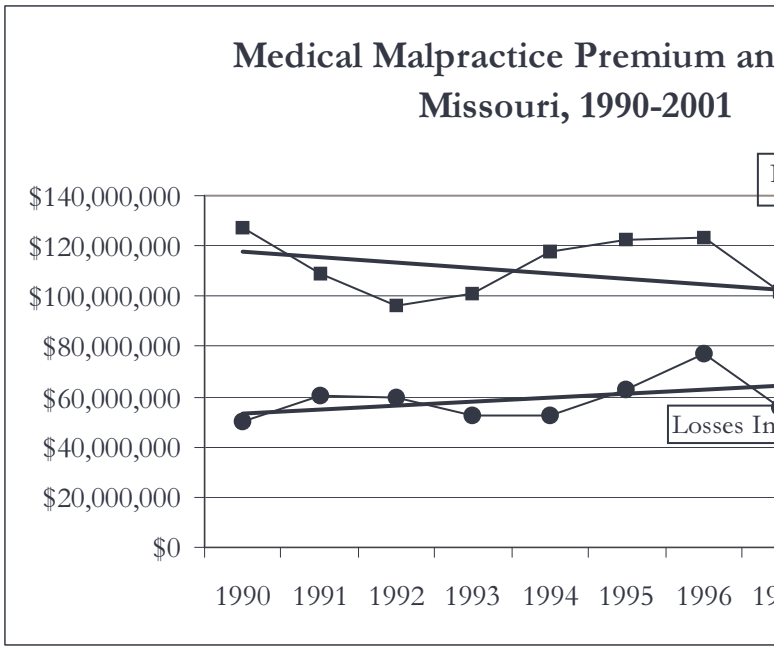
Year	Claims closed	Closed with payment	$1 million-plus awards	$2 million-plus awards
1988	2,037	753	1	0
1989	1,813	618	2	0
1990	1,815	644	3	1
1991	1,855	646	7	0
1992	1,888	558	8	3
1993	1,892	559	8	2
1994	1,754	552	4	2
1995	1,930	640	4	0
1996	1,901	604	11	5
1997	1,625	530	8	2
1998	1,624	496	8	3
1999	1,622	545	3	1
2000	1,534	434	8	0
2001	1,288	439	9	1
2002 (9 months)	875	317	4	1

Profitability in the Missouri market

Loss ratios

Premium and loss data for Missouri indicate two unambiguous trends, both of which have created profitability strains on malpractice providers in the admitted market.

- **Between 1990 and 2001, (1) total earned premiums tended to decline while (2) claims costs have increased incrementally.**



Since 1999, the result has been higher loss ratios -- the percentage of premium earned that is paid out or reserved for future payments -- than had been experienced earlier in the decade. Between 1990 and 2001, earned premium declined by 24 percent[7] while claims payments increased by 36 percent, resulting in elevated loss ratios beginning in 1999. (The year 1996 was an anomaly created when five carriers dramatically increased their reserves.)

Medical Malpractice Insurance, Premium and Losses

(Admitted Market Only)

Missouri, 1990-2001

Year	Premium Earned	Losses Incurred	Loss Ratio
1990	$127,371,871	$58,030,387	45.6%
1991	$108,788,193	$57,589,693	52.9%
1992	$96,442,625	$50,971,777	52.9%
1993	$101,049,704	$57,543,001	56.9%
1994	$117,860,545	$65,449,209	55.5%
1995	$122,240,889	$61,756,820	50.5%
1996	$123,401,931	$117,608,550	95.3%
1997	$101,923,637	$54,273,811	53.2%
1998	$88,559,722	$48,185,927	54.4%
1999	$93,676,069	$68,353,073	73.0%
2000	$91,969,348	$65,056,683	70.7%
2001	$97,027,590	$79,027,069	81.4%

Loss Ratio by Malpractice Specialty

Line	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Physicians	67.5%	65.6%	66.2%	51.7%	58.1%	113.3%	61.4%	79.5%	63.1%	96.7%	60.9%
Dentists	28.4%	18.6%	83.9%	21.0%	-10.4%	32.6%	45.1%	17.1%	-20.2%	11.5%	34.8%
Nurses	-92.6%	52.1%	-22.1%	98.1%	28.9%	-92.5%	-54.1%	21.2%	34.6%	222.6%	31.0%
Hospitals	29.1%	8.5%	23.3%	85.1%	30.7%	91.5%	15.0%	19.7%	72.6%	8.7%	160.4%
Other	11.3%	82.9%	63.2%	33.8%	44.5%	38.4%	59.7%	-7.1%	191.5%	-28.8%	111.9%
Total	**52.9%**	**52.9%**	**56.9%**	**55.5%**	**50.5%**	**95.3%**	**53.2%**	**54.4%**	**73.0%**	**70.7%**	**81.4%**

Source: Missouri Supplement Data

Loss ratios for these specialties fluctuate, sometimes dramatically, from year to year because a relatively small number of claims are closed. A more accurate picture may emerge if a moving average over five years is used. The unusual spike for physicians in 1996 skews this picture, so the loss ratio for 1997 to 2001 appears to decline.

Missouri Loss Ratio
Five-Year Averages

Line	1991-1995	1992-1996	1993-1997	1994-1998	1995-1999	1996-2000	1997-2001
Physicians	61.3%	71.2%	70.5%	72.7%	75.9%	84.6%	71.9%
Dentists	27.7%	28.5%	33.7%	21.1%	13.7%	18.8%	18.9%
Nurses	9.9%	10.2%	-15.5%	-8.4%	-29.5%	-11.0%	26.8%
Hospitals	35.4%	47.5%	51.6%	52.8%	49.0%	40.3%	51.4%
Other	46.6%	48.5%	48.2%	36.7%	55.2%	60.7%	78.3%
Total	**53.7%**	**63.0%**	**93.0%**	**62.7%**	**66.1%**	**70.8%**	**66.6%**

Source: Missouri Supplement Data

Losses in these ratios consist of three parts: actual payments on incidents that occurred during the year; actuarial projections of future payments for those losses, which are known as reserves; and corrections for reserve errors in previous years. When those reserves are overestimated (or underestimated), this practice can lead to misleading impressions of the profitability of the line.

NAIC profitability figures

The National Association of Insurance Commissioners[8] (NAIC) publishes data on fixed expenses, underwriting profit, taxes and investment income by state that allow calculation of profitability for Missouri only.

- **Based on NAIC data, the medical malpractice sector's bottom-line difficulties date at least from 1997, although it did not become apparent in market behavior until the current economic downturn. Medical malpractice insurance in Missouri was still slightly profitable in 2000, the last year of available data, when MDI began seeing the first substantial rate hikes by carriers.**

Other than the anomalous year of 1996, the medical malpractice line had posted among the most robust profits of any insurance sector from the late 1980s through 1997. The year 1997 produced the last year of underwriting profits (profitability without investment income or tax offsets). Investments protected the bottom line in 1998. After-tax profitability plummeted from 17.5 percent of premium earned in 1998 to a 7 percent loss in 1999. The line rebounded in 2000, thanks to an upturn in investment income and tax treatment, again posting a slim profit. Figures for 2001 are not yet available, but gross losses were 16.7 percent for the entire market including surplus lines companies and 14.5 for regulated malpractice insurers in Missouri. Those figures will decline, possibly significantly, after federal taxes are computed. In 1997, for example, a 14 percent gross loss was reduced by half through tax offsets.

As expected, investment income turned downward in 2001 as the stock market and interest rates slipped sharply. Missouri malpractice insurers invest slightly more than half of their portfolio in bonds, and that figure rises substantially for insurers that specialize in medical malpractice coverage; common stock holdings total about 30 percent overall. This conservative approach to investment protects insurers from much of the stock market's erratic behavior, but they have suffered financially from the Federal Reserve Board's steady cutting of interest rates that influence bond performance. This downward trend in investment income certainly continued in 2002 for interest and stock market income and further removed the cushion that insurers use to offset underwriting losses.

Missouri Medical Malpractice Profitability Results

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Underwriting Profit											
Admitted Market							11.5%	-3.1%	-38.5%	-29.0%	-36.0%
Total Market	-5.8%	6.8%	10.2%	1.5%	0.3%	-46.1%	16.0%	-6.4%	-34.9%	-28.1%	-39.2%
Investment Gain											
Admitted Market											21.5%
Total Market	26.7%	37.5%	27.6%	17.8%	20.2%	23.7%	27.0%	29.4%	20.9%	27.1%	22.5%
Gross Profit on Insurance Transaction (Before Taxes)											
Admitted Market											-14.5%
Total Market	20.9%	44.3%	37.8%	19.3%	20.5%	-22.4%	43.0%	23.0%	-14.0%	-1.0%	-16.7%
Net Profit on Insurance Transaction (After Taxes)											
Admitted Market											
Total Market	17.8%	33.9%	28.1%	15.4%	16.0%	-11.9%	30.9%	17.5%	-7.05	1.5%	n/a

Source: 1991-2000 Total Market Figures -- *NAIC, Profitability By Line by State in 2000.* Figures for 2001 and for all "admitted market" are MDI calculations based on NAIC annual statement data, where calculations adhered to NAIC profitability formulas. Net (after tax) profits for 2001 were unavailable at the time of publication. Losses will be less than the –16.7 percent figure for gross profits, perhaps significantly so, due to tax offsets.

Competition in the current market

The affordability crisis of the early 1980s occurred after mounting losses, real or projected, convinced major carriers of the need for significant premium increases. The losses also prompted Missouri, among other states, to adopt reforms in 1986 that reduced the liability of physicians, other health-care providers and their insurers for patient injuries or deaths.

National and Missouri data indicate the losses peaked in 1984 and rapidly began declining. Combined with major increases in premiums in the late 1980s, the drop in losses boosted substantially the profitability of the line. By 1988, Missouri quickly had established a highly profitable medical malpractice market with only 45.6 cents of benefits paid or reserved for every $1 in premium earned by the carriers.

With the decline in losses, major insurers like St. Paul Fire and Marine Insurance Co. – the national leader in medical malpractice writings – began releasing "over-reserves" that had been set up for losses.[9] This shift improved the financial performance of those insurers and made medical malpractice appear to be an attractive area for expansion by other insurers.

Underpricing and insolvencies

Several provider-controlled insurers – including PIE of Ohio, PHICO of Pennsylvania, PIC of Pennsylvania, Scpie of California[10] and MIIX of New Jersey[11] – expanded beyond the boundaries of their original states of "domicile" and principal marketing. These entities often used aggressive pricing strategies to establish and expand beachheads elsewhere. PIE and PHICO grew quickly in Missouri.

Many companies also had little "feel" for the legal and medical environments into which they were expanding, which can feed inaccurate actuarial projections on rates. Some did little more than copy the rate filings of apparently successful and lower-priced companies when they entered the Missouri market.

Medical malpractice is particularly susceptible to inaccurate pricing because companies cannot respond quickly to errors. Medical malpractice is known as a "long-tail" line — the precise extent of the insurer's liability is not known for years because frequency and extent of injuries often are not known for years and litigation requires further years to complete. Missouri's *average* of almost four years to pay a claim actually is quite short compared to other states in which the injured patient can wait a decade or more for any payment of lost wages and medical costs.

This lengthy delay in learning actual costs leaves insurers that have pursued inadequate pricing with few alternatives, particularly if they have sold "tail" insurance that covers claims filed after the policy period ends.

This nature of the line also frustrates state regulators that have few means to prove and correct underpricing or overpricing, if that occurs during periods of constricted supply.

The case of **PIE Mutual**, whose entry into the Missouri market had been hotly contested, is particularly instructive on underpricing. By 1996, its last full year of operation, PIE had one-fifth of the physicians' coverage in the state and 13 percent of the entire market; it ranked second in premium volume for both areas. The Ohio Department of Insurance later reported in receivership proceedings that the company's claims exceeded its assets by $275 million, or almost three times the entire medical malpractice premium paid in Missouri.

PHICO has been the latest of the major medical malpractice insurers to become insolvent. In August 2001, the Pennsylvania Department of Insurance obtained a court order to take control of the insurer, and liquidation of assets began in early 2002. Its "negative surplus" was believed to total $250 million despite filed financial statements to the contrary. In 2000 – the last full year of its Missouri operations – PHICO ranked No. 6 among all medical malpractice insurers with $7.6 million in written premium and 8.2 percent of the entire market. It was the 5th-largest writer for Missouri doctors with 7.8 percent market share. Only the year before, PHICO had been the largest writer with 21 percent of the entire market and 24 percent of physicians, or almost twice the size of the next largest competitor.

PHICO's departure from the Missouri market in August 2001 was the first in a series that affected competitiveness of the market. In December 2001, **Chicago Insurance Co**. and its affiliate in the Fireman's Fund group, **Interstate**, announced a moratorium on new accounts and then withdrew from physicians' medical malpractice nationally; Chicago reportedly had been among the least expensive insurers for Missouri physicians. Also in December, **St. Paul** announced its plan to withdraw from medical malpractice nationally after 65 years in the business.[13]

Legion Insurance Co. went into receivership, again in Pennsylvania, in March 2002; a small insurer, it had less than 1 percent of the Missouri market. But **North American Specialty Insurance Co**., which had been "fronting" for the defunct PHICO, stopped writing business as well; its premium had totaled almost 4 percent of the Missouri market in 2001.

Withdrawals from Missouri Medical Malpractice Market

Company	2001 MO market share[12]		2001 MO loss ratio
	Overall	Physicians	Physicians/Surgeons
PHICO	8.2%	7.8%	99.4%
Chicago/Interstate	9.4%	23.4%	73.4%
St. Paul	5.4%	4.2%	31.6%
Legion	0.4%	0.5%	21.0%
North American Specialty	2.8%	3.9%	44.5%
Total	**26.2%**	**31.6%**	

Market capacity severely contracted in May 2002 when **Intermed Insurance Co**. – the state's largest medical malpractice insurer for doctors in 2001 with 26.1 percent of premium – stopped writing policies for physicians who were new applicants because of a major rating agency's warning about further expansion given its capital structure.

The shrinking 2002 market for physicians

In the most immediate effect of these insolvencies and withdrawals, hundreds of physicians and other health-care providers received written notice in late 2001 and 2002 that their coverage would end when their policies expired or, in the case of PHICO, before. Physicians sometimes received only 30 days notice of their nonrenewals. While a month generally is adequate time to find alternative coverage in a normal market, it is insufficient in a "hard" market when hundreds of doctors flood a small number of carriers. Only three insurers generally were available for doctors by mid-2002: Medical Assurance Co., Medical Protective Co. and the Doctors Company.

June and December are the periods when most physicians shop for coverage if they have been nonrenewed or are dissatisfied with rates because policies most commonly expire Dec. 31 (calendar-year policies) or June 30 (policies typically issued after medical students begin practicing). **For those physicians with a June 30, 2002 expiration date who needed to locate a new carrier, the circumstances were dire: between the withdrawals and declination of new business by Intermed, more than 57 percent of the Missouri market had disappeared in the past year for doctors who were seeking new carriers.**

The companies still writing, if they wished to expand, were handicapped by inadequate underwriting staff to satisfy demand. For example, Medical Assurance Co. – the No. 3 carrier for Missouri doctors in 2001 – was overwhelmed by applicants and was forced to hire and train new underwriters, according to its testimony at an October 2002 MDI public hearing. Physicians complained that quotes on new coverage, if they arrived, often did not come until the day their old policies expired.

In these circumstances, it is not surprising that about 13 percent, or 75, of the 582 doctors responding to a Missouri State Medical Association survey in the fall 2002 had been unable to locate other coverage, even if carriers had not become more selective and raised rates substantially.

Doctors reacted with alarm because many could not practice without coverage. For those on staff in urban hospitals, they faced losing privileges under state law if they did not obtain at least $500,000 in coverage. Since 1997, health maintenance organizations have tended to require that doctors have at least $1 million in coverage per occurrence and $3 million overall during the policy's life if they wished to remain in the networks, which provided the bulk of their patient caseload.

This shift in competitive structure of the market occurred quite suddenly. At the end of 2001, insurer reports to the Missouri Department of Insurance indicated that 32 carriers were still writing physician coverage alone, up from 27 the year before. Such numbers would have been more than adequate for the market. The depth and breadth of the availability shrinkage became apparent in late summer 2002 when MDI conducted a survey of medical malpractice writers that provided greater insights into market dynamics.

Many were no longer writing physicians, had stopped offering coverage to new applicants or were covering only a few of the more than 300 categories of doctors.

According to the survey results, many carriers were restricting coverage of higher-risk physician specialties, such as general surgeons, neurosurgeons, orthopedic surgeons, obstetricians and emergency room doctors. These physicians tend to have the highest rate of claims and already paid the highest malpractice rates. The regular commercial market was providing few alternatives for these practitioners, who increasingly were turning to the "surplus lines" or specialty markets for coverage that is much more expensive.[15] These physicians also were the most heavily represented in the MSMA survey.

Rate regulation in Missouri

Missouri law gives MDI extremely limited authority to reject company medical malpractice rates unless 1) they are excessive or inadequate *and* 2) the market is no longer competitive.

MDI traditionally has relied on its authority to regulate casualty or liability rates under Sections 379.420 to 379.510, RSMO. The key Section 379.470 provides that:

1) Rates shall not be excessive or inadequate…nor shall they be unfairly discriminatory.
2) No rate shall be held to be excessive unless such rate is unreasonably high for the insurance provided and a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable.
3) No rate shall be held to be inadequate unless such rate is unreasonably low for the insurance provided and the continued use of such rate endangers the solvency of the insurer using the same, or unless such rate is unreasonably low for the insurance provided and the use of such rate by the insurer using same has, or if continued will have, the effect of destroying competition or creating a monopoly.
4) Due consideration shall be given to past and prospective loss experience within this state and consideration may also be given to past and prospective loss experience outside this state to the extent appropriate….

A state regulation (20 CSR 500-4.100(1)(b)) then requires the filing of policy forms, rating manuals, rating plans and modifications within 10 days after their effective dates. In other words, medical malpractice insurers can begin using new policies and rates before they are filed with MDI.

The law does not define "unreasonably high" nor does it specify how MDI would determine whether "a reasonable degree of competition" exists.

Missouri and other states with similar "use and file" systems have relied on the competitive market to regulate rates. In recent practice, MDI product analysts have asked the property and casualty actuary to review filings when they consider the filing to be insufficiently documented or the rate increase exceeds 25 percent.

Premium costs drop from 1990 to 2001

Both physicians and all medical providers in Missouri pay less total premium today for medical malpractice coverage than they did in 1990. The overall expense for physicians is less, even though Missouri's number of licensed instate doctors grew from 9,797 in 1990 to 13,459 in 2001, or by 40 percent.

All medical care providers paid $127 million for malpractice policies in 1990, compared to $97 million in 2001, a decline of 24 percent. Today, data is available (unlike in 1990) on the non-admitted or surplus lines market, and providers purchased another $22.2 million there. So medical professionals and facilities were paying less than $120 million in 2001 — compared to $127 million in 1990 *plus* whatever sales took place in surplus lines. That translates into a nominal decline of at least 5.5 percent. (Health entities that self-insure did not report in either 1990 nor 2001.)

For physicians only, the malpractice bill in the admitted market dropped to $68 million in 2001 from $94 million in 1990, or a reduction of 28 percent. (Premium figures in the surplus lines market are not available for physicians and surgeons in either 1990 nor 2001.)

The declines for both all providers and physicians are even more dramatic if the figures are adjusted for inflation.

Not every licensed doctor needs medical malpractice insurance or is required to insure. But using figures from the Board of Registration for the Healing Arts, the average medical malpractice costs per licensed *instate* doctor fell from about $6,500 in 1990 to $4,900 to 2001 in the admitted market.

Premium rate increases

In 2002, nonrenewed physicians seeking new carriers also confronted the results of two years of solid rate increases from most of the state's major carriers. From the early 1990s through the end of the decade, rate increases for physicians had been extremely rare, and many doctors enjoyed substantial discounts from officially filed rates that are not subject to monitoring by MDI.

Medical malpractice rate changes, 1999-2002

(Missouri market only)

Company	2001 market share	Overall rate change[15]	Effective dates
Intermed Insurance Co.***	26.1%	65.8%	11/1/00, 11/1/01, 7/1/02
Medical Assurance Co.	16.2%	96.9%	4/1/00, 9/1/01, 10/1/02
Medical Protective Insurance	10.8%	45.6%	1/1/99, 5/1/00, 5/1/01, 5/1/02
The Doctors Company	6.4%	27.5%	10/1/00, 4/1/02, 5/1/02, 8/1/02
Zurich American Insurance Co.	2.3%	none	none
Preferred Professional	1.6%	37.5%	1/1/01, 1/1/02
Missouri Hospital Plan	0.9%	none	none
Truck Insurance Exchange (Farmers)	0.9%	10.0%	7/15/01
Continental Casualty Co. (CNA)	0.4%	100.0%	10/1/00
PHICO Insurance Co.*	n/a	29.0%	7/1/00
Chicago Insurance Co.**	23.4%	39.3%	10/1/00
St. Paul Fire and Marine**	4.2%	none	none

* Insolvent, August 2001
** Withdrawing from national markets
*** No longer writing for new applicants

In the past three years, the rate behavior of most carriers was clearly at odds with the Insurance Services Office (ISO), an industry rate advisory group, which files "loss costs" on behalf of smaller companies in the Missouri market. ISO's loss-cost filings for Missouri would have translated into *reductions* in each of the past three years: a negative 7.1 percent in May 2000; negative 2.2 percent in March 2001; and negative 6 percent in March 2002. The cumulative change would reduce costs by 15 percent, assuming no changes in such other expenses as loss adjustment, reinsurance and administration.[16]

The Missouri State Medical Association 2002 survey found the 582 respondents – about 10 percent of its members — had faced average premium increases of 61.2 percent in 2002 alone, with some facing much larger costs. The same survey found those doctors had experienced *average* premium increases of almost 100 percent over a two-year period (likely the two renewal cycles in the 13 months from June 2001 to July 2002). MSMA agreed that these motivated respondents

likely represented the higher end of rate increases and availability problems in Missouri; about 75 doctors indicated they could not find alternative coverage.

In meetings with MDI and at the public hearing Oct. 30, doctors said these premium increases exacerbated a "cash flow" problem that has occurred because, unlike many businesses and the medical business a decade ago, they cannot pass along higher costs. Reimbursements from their key income sources – managed care plans, Medicare and Medicaid – have been static or declining with little cushion available to absorb these increases. Obstetricians, for example, are heavily dependent on Medicaid, which pays for more than 40 percent of the live births in Missouri.

Dozens of physicians also took advantage of MDI's Internet Public Portal to comment on medical malpractice and voiced resentment that the remaining carriers in the market were taking advantage of their position to "price-gouge," compounded by reaction to the last-minute quotes on coverage. In particular, physicians complained about unjustified surcharges for pending, unsettled claims – even though the insurers indicated they did not levy such extra premiums.

The insurers differed on the rationale for the major price increases that new applicants experienced. From their perspective, the carriers that left the market had been underpricing the product for many years, so physicians switching to the more conservative insurers should expect a rate increase, sometimes substantial. Some departing carriers allegedly were charging discounted prices of 40 to 60 percent below other insurers. Physicians also may have been covered by previous insurers that did not surcharge for past history, so these could have experienced further premium increases if they had several paid claims.

In these cases, the switch to new carriers would involve a one-time "rate shock" rather than a long-term pattern of increases that characterized periods around 1976 and 1986.

New entrants eye Missouri physicians market

Early signs point to increasing interest from the provider community in the Missouri market for physicians, which would increase capacity and spur price competition.

Since mid-2002, plans associated with the Minnesota and Wisconsin medical societies gained licenses for the Missouri market. A new affiliate of NCMIC, a large medical malpractice insurer devoted previously to chiropractors, has applied for licenses in Missouri and other states. Organizers of a new Missouri physicians mutual have applied for licensing under Chapter 383, RSMo.

And the Missouri Hospital Plan (the state's sole provider-controlled insurer operated by the Missouri Hospital Association), working through its Medical Liability Alliance subsidiary, plans to expand its offerings for physicians; in March it will offer coverage for physicians who are on staff at the hospitals rather than just the doctors directly employed by hospitals. Particularly this entry into the physicians market could increase price competition in the near future.

Potential solutions to Missouri's medical malpractice difficulties

Caps on total damages

Seven states have adopted limits on total damages that injured patients can recover from health-care providers for lost earnings, medical care and non-economic damages: Colorado, Indiana, Louisiana, New Mexico, South Dakota and Virginia. Kansas' attempt to impose an overall limit was ruled unconstitutional in 1988[17]; a trial court struck down Nebraska's lid in June 2000, and the state Supreme Court is considering the appeal.[18]

The change has not guaranteed low loss-ratios for medical malpractice insurers – note New Mexico in the accompanying chart – but these states generally have very low comparative losses by medical malpractice carriers. (It does raise questions about why providers are paying such relatively high premiums in some of these states if losses are so low. For example, loss ratios were only 46.7 percent in Colorado; 41.3 percent in Indiana; 38.4 percent in Louisiana; 38.2 percent in Nebraska; and 52.2 percent in South Dakota.)

Neither President George W. Bush nor HR 4600, which passed the U.S. House last September, has proposed denying patients the right to recover all of their lost earnings or the cost of their medical treatment, as have these states. Far preferable is Missouri's method of periodic payment of damages, under which an insurer can request for awards of more than $100,000; this approach particularly mitigates against lump-sum settlements swollen by medical costs that do not materialize (if the patient dies).

Such caps on total damages do provide certainty to the risks faced by the insurance industry, but can impose substantial future costs on the injured patient, the family and eventually government programs for care and lost income.

MDI is aware of no interested party, including insurers, that seriously is proposing such a cap in Missouri. With the court action in Kansas and Nebraska, no neighboring state has an effective overall cap on damages.

Reduced cap on non-economic damages

For the past 25 years, the debate on controlling medical malpractice insurance costs has centered on reducing the compensation paid to patients or their survivors for the non-economic damages of their injuries. These damages, popularly are known as "pain and suffering," refer to a broader, more intangible kind of loss, like physical pain. These damages encompass all the new limitations that decrease the patients' quality of life – chronic pain, disfigurement, emotional distress, life with physical difficulties and/or reliance on daily custodial care, inability to have children and damage to the marital relationship – or that are faced by the dead patients' survivors, such as loss of consortium,[19] hardships on the remaining parent or damage to the family relationship.

Missouri courts simply have directed juries to settle on awards that are "fair and reasonable." Said one 1978 decision:

> One of the most difficult decisions facing the jury in a personal injury action is to decide the amount of the monetary award, if any, that the plaintiff is entitled to be awarded as compensation for past, present and future pain and suffering. The measure of damages for pain and suffering in this state is and has been what is fair and reasonable.... There is no fixed measure, table or standard which the jury can use as an accurate index to establish an award of damages. No method is available to the jury by which it can objectively evaluate such damages....
> *Graeff v. Baptist Temple of Springfield*, 576 SW2d 291 (Mo banc 1978)

Because of the intangible nature and lack of guidelines for setting awards, insurers have been particularly critical of the unpredictability of these damages in states without caps. Even in Missouri, which has had caps for more than 15 years, insurers complained of unpredictable juries and awards in the fall 2002 MDI survey.

The national movement to caps on non-economic damages began in 1975 when California, reacting to the inability of thousands of physicians to obtain insurance during that national crisis, enacted a $250,000 lid. The cap was not subject to inflation; if it had been, the lid would have been lifted to $546,000 in 2002. The failure to index has created a loss of almost $300,000 in purchasing power for the most seriously injured patients and families.

In 1986, Missouri became one of the states (today 18) that cap non-economic damages. The Missouri General Assembly enacted a $350,000 limit, subject to annual adjustments by the Department of Insurance to reflect increases in the federal consumer price index. In 2002, the Missouri limit was $547,000, or almost exactly the California amount if it had been indexed.

Except for Kansas' $250,000 limit, no neighboring state has adopted lids on non-economic damages. Nebraska had a de facto limit of $1.25 million on all damages, including non-economic.

States with caps on medical malpractice damages

State	Premium earned 2001	Losses incurred 2001	Loss ratio	Limits on non-economic damages
Alaska	$13,293,309	12,597,719	94.8%	$400,000 with exceptions
California	$644,513,658	416,926,519	64.7	$250,000
Colorado	*$97,550,663*	*45,597,857*	*46.7*	*$250,000 with $1 million total*
Hawaii	$30,074,426	20,830,292	69.3	$375,000 with exceptions
Idaho	$21,812,351	21,528,993	98.7	$400,000 adjusted annually
Indiana	*$58,683,466*	*24,210,659*	*41.3*	*$1.25 million cap*
Kansas	$45,795,108	32,241,839	70.4	$250,000
Louisiana	*$81,910,566*	*31,432,473*	*38.4*	*$100,000 with $500,000 for all damages*
Maryland	$182,617,595	201,363,731	110.3	$500,000
Massachusetts	$155,175,190	147,725,882	95.2	$500,000 adjusted annually
Michigan	$176,596,758	106,657,813	60.4	$280,000 with exceptions adjusted annually
Missouri	**$119,264,941**	**100,199,202**	**84.0**	**$350,000 adjusted annually**
Mississippi	$44,517,385	88,223,697	198.2	$500,000 adjusted with exceptions (2002)
Montana	$17,343,074	20,737,185	119.6	$250,000
North Dakota	$12,886,419	11,079,257	86.0	$500,000
Nebraska	*$22,354,359*	*8,530,241*	*38.2*	*$1.25 million for all damages*
Nevada	$57,249,341	76,479,000	133.6	$350,000 with exceptions (2002)
New Mexico	*$29,899,908*	*60,016,937*	*200.7*	*$600,000 for all damages with exceptions*
Ohio	$299,682,201	319,650,997	106.7	$250,000 to $500,000
South Dakota	*$10,529,290*	*5,492,608*	*52.2*	*$1 million for all general damages*
Utah	$37,131,283	38,151,193	102.7	$250,000
Virginia	*$141,270,379*	*125,320,585*	*88.7*	*$1.5 million adjusted periodically*
Wisconsin	$64,048,496	19,854,728	31.0	$350,000 adjusted annually
West Virginia	$76,930,120	74,531,461	96.9	$1 million
Countrywide	***6,998,177,384***	***6,814,160,297***	***97.4%***	
States with all caps	***2,441,130,286***	***2,009,380,868***	***82.3%***	
States with non-economic caps	***$1,998,931,655***	***1,708,779,508***	***85.5%***	

Source: National Association of Insurance Commissioners
Italics = states with overall caps, not just non-economic damages
Current through late 2002

Loss ratio data based on admitted (regulated) and surplus lines markets; Missouri's loss ratio is higher than cited elsewhere in this report because the non-admitted or surplus lines market is included here.

Non-economic damage caps, or those combined with general caps, have been ruled unconstitutional in Florida, Illinois, Alabama, New Hampshire, Oregon, South Dakota, Texas, Washington and recently Nebraska. The Kansas total damages cap was struck as unconstitutional.

Advocates of reducing the maximum non-economic damage award to $250,000 maintain that the change would remove incentives for *attorneys* to pursue these cases, cutting the cost of the medical malpractice system and eventually premiums.

However, lowering the caps further in Missouri would come at considerable cost for the small number of cases in which patients suffered the greatest damage. **MDI prefers to look elsewhere for solutions first, rather than reducing the compensation of victims.**

If Missouri adopted the $250,000 lid, any relief for physicians and other health-care providers would not take place for several years and would amount to much smaller savings than physicians are demanding. After the Nevada and Mississippi legislatures in 2002 passed most if not all the reforms requested by insurers, including caps for the first time, doctors there were stunned to learn that they would need to wait several years for any meaningful reductions in insurance premiums. After passage, the insurers announced that they would wait to reduce premiums until the statutory changes have been tested in court and produce bottom-line results. With the "long tail" of medical malpractice and the lengthy time needed for appellate review, these changes could take years, often three to five.

Such caps have been criticized because they reduce compensation disproportionately for the young, seniors and women who do not work outside the home. Because young people often have not made career choices, their economic damages from lost earnings generally reflect minimal amounts. Homemakers, full-time mothers and retired persons usually do not have earnings affected by the medical error and resulting injury. If their medical treatment is provided through insurance, Medicaid or Medicare, non-economic damages are the only compensation received.

President Bush in January reiterated his plans to press for congressional approval of $250,000 limits on non-economic damages. Although the White House did not release details of his proposal, HR 4600 that passed the House last September with the President's endorsement would not have changed Missouri's limits. **The legislation would have affected only those states that had no limits.**

If the caps here shrink to the California MICRA levels, damages to injured patients would have been reduced by $8.1 million in Missouri in 2001. The reductions, affecting 37 cases altogether, would have been equal to 20 percent of non-economic damages, but only 10 percent of total amounts paid. Because the change would not have affected administrative costs, reinsurance, loss adjustment expenses, dividends and other expenses, the effect on reducing premiums would have been considerably less. Doctors, meanwhile, are complaining of 40 to 100 percent increases in premiums.

The number of claim awards that reach Missouri's indexed caps has drifted steadily downward since reaching a peak of 23 cases in 1992. In 2001, the maximum amount was awarded in only six cases, or 1.3 percent of all claims closed with payment and 0.4 percent of all closed claims. (See chart, page 19.) The average claims involve quadriplegia, blindness, lifetime care and other permanent severe or grave injuries or death as a result of the medical error.

Even taking into account economic damages for medical treatment and lost earnings, few Missouri cases produce the multimillion-dollar awards that gain media attention. (See chart, page 20.) In the 15 years since Missouri's 1986 reforms, only 21 cases have received awards exceeding $2 million; in the past five years of data available, 32 reached $1 million. The number peaked in 1996, when 11 claims received awards of more than $1 million and five reached $2 million. The bulk of these awards involve economic damages that would not change under proposed tort revisions. Such figures are not difficult to reach if the injury results in permanent handicaps, inability to work and lifetime medical care for a younger or middle-aged professional or business executive.

MDI did examine 24 cases in which the final awards in 2001 were more than 200 percent of the insurers' estimates of the damages – and might substantiate claims of "runaway" juries. Most (21) of the cases involved at least significant, permanent injury, with more than half (14) involving the death of the patient; nine of the cases involved newborns with the child dying in five cases. In only three of the 24 cases were minor injuries involved, with an average award of $75,000.

State provision of medical malpractice insurance

Prompted by the crises of the 1970s and 1980s, direct state provision of medical malpractice insurance has taken two main forms: joint underwriting associations (JUAs); and patient compensation funds.

A JUA addresses malpractice availability problems by giving physicians an "insurer of last resort," operated by the state, with its deficits spread in prorated shares to all casualty companies. The cost of insurance under a JUA is almost always more expensive than private insurance. Twelve states have active JUAs that provide medical malpractice coverage. Nine states – including Missouri – have statutory authority to operate a medical malpractice JUA, but have not activated one.

Among the difficulties faced by JUAs is maintaining prices that are affordable for physicians and others while avoiding the political temptation to set premiums that require all ratepayers to subsidize the legitimate business costs of physicians and other health-care providers. If premiums are too low, the state becomes the insurer of first resort, and the private medical malpractice market withers. If premiums are priced above market averages, then affordability problems are not eased. States could find that they become the insurer of "only resort" for physicians and other providers that have extensive claims histories and have become active partners in allowing unsafe practitioners to continue operating. Such JUAs also tend to lose all but the least insurable providers when the markets turn "soft" and price competition returns.

Fourteen states, including Kansas, have established patient compensation funds to provide coverage in excess of the coverage limits of a malpractice insurance policy. In these states, physicians participating in the fund are required to purchase private medical malpractice insurance, for example, for $200,000 per injury and $600,000 total coverage. The state fund then covers awards up to a maximum that, in some states, represents the total amount that an injured patient can receive from economic and non-economic damages combined. At least three of the patient compensation fund states also require all physicians practicing there to carry medical malpractice insurance, which Missouri does not; in the others, participation is voluntary, but strongly

encouraged because judgments against providers often are not subject to damage caps unless they join.

Many of these patient-fund states have healthy loss-ratios, but others have been plagued by operating difficulties – they are much larger operations than many insurers, with almost all state physicians participating. Their financial positions range from deficits of $38 million to a balance of $576 million. These funds also have become targets of the physician community because of surcharges that now make annual fees more expensive than their private insurance. Pennsylvania, for example, is eliminating its fund and ceding those responsibilities to the private sector.

MDI recommends that the General Assembly revise state law to allow Missouri to establish a workable, limited-scope joint underwriting association to offer medical malpractice for distressed specialties.

The insolvency, withdrawal and moratoria on new business by medical malpractice insurers with more than half of the Missouri physicians market since mid-2001 has severely reduced the private capacity to provide this coverage. Even if insurers did not face profitability pressures, such an exodus – which did not stem from Missouri market or tort conditions – would place physicians at a serious disadvantage in obtaining, retaining and paying for medical malpractice insurance.

MDI remains committed to the free market as the best long-run mechanism for providing affordable coverage. However, the largest carrier ceased writing new business and anticipates dropping a substantial number of policyholders upon their next expiration date; only three companies of appreciable size are regularly offering policies to new physician-customers.

It is highly debatable whether the market is any longer competitive for providing medical malpractice coverage for several higher-risk specialties, including obstetricians, neurosurgeons, orthopedic surgeons, trauma and emergency room physicians and perhaps all general surgeons. In the heavy July 2002 renewal cycle, the remaining writers were not prepared to handle the crush of new applications received. Restricted supply in the face of increasing demand inevitably promotes higher prices among remaining carriers, and the "long tail" nature of this line complicates regulatory attempts to prevent overpricing.

Several companies are interested in entering Missouri's physician market. Generally, though, these carriers will require time to establish themselves and restore the degree of competition found here not long ago.

Besides addressing the currently constricted supply of coverage, Missouri needs to act to protect public health and safety because the physicians most greatly affected are critical to accident victims, those who need surgery and pregnant mothers. Most rural Missouri counties already have physician shortages, and the state should act to prevent the departure of existing physicians there or decisions by family practitioners to drop obstetrics.

Chapter 383, RSMo, already has provisions for the director of insurance to establish a joint underwriting association that would assess all casualty (liability) insurers in the state on a pro-rata

basis for startup costs and any operating deficits. The statute, however, is not workable in today's environment because 1) the JUA would have to charge double the rates available in the private market for a physician's first year of coverage, 2) the financing structure would impose substantial costs on the general revenue fund and 3) it is unclear whether the JUA could limit its scope to medical providers that have the greatest difficulty obtaining coverage and greatest importance to the public safety.

Statutory changes must address these deficiencies before a limited-scope JUA can function properly.

The program would have a structure that would not erode state revenues through tax credits or other loss of premium tax revenues that exist under current law.

The JUA should have the ability to charge rates that are actuarially sound, unless the legislature agrees that subsidies are necessary. Considerable evidence exists that medical malpractice was substantially underpriced during the late 1990s, and the insurers responsible largely have withdrawn or gone insolvent. But JUA rates that are actuarially sound also could guard against premium charges that may represent the other extreme -- "price gouging" -- or inaccurate projections by private insurers during this period of transition to a more provider-friendly market.

MDI is not proposing that the state enter the medical malpractice business on a long-term basis or on a major scale. A JUA is expected to have a rather short life span (possibly three years or less) after which most of the state's insurers believe the hard market for pricing and availability should ease. The three years would cover a transition period in which the medical malpractice industry could adjust and expand its own resources to meet the demand in Missouri.

Many Missourians – including all homeowners – are experiencing substantial premium increases in this "hard" property and casualty market while HMO premiums rose 47.9 percent from 1999 to 2001; so most residents are experiencing "rate shock." But this JUA effort is targeted at those medical specialties that are most dramatically affected by rate upgrades *and* are deemed essential to the public safety.

Finally, the JUA cases would represent an opportunity for Missouri to test new approaches to claim defense, other facets of medical malpractice litigation and requirements to improve patient safety.

The JUA could operate under control of the director, as prescribed currently in Chapter 383, or under a different governing structure. A considerable number of states operate JUAs or patient stabilization/compensation funds (excess liability funds), so numerous governing models are available.

Commission on patient safety

The governor should immediately establish a Missouri Commission on Patient Safety to explore ways to reduce negligent medical errors that drive the cost of malpractice and permanently disable and/or result in the death of residents.

Missouri's business community reduced its workers compensation insurance costs by 25 percent in the 1990s because it took steps to improve workplace safety and reduce on-the-job injuries even though medical costs and wages were rising. Missouri's medical community also could reduce its medical malpractice costs in the long run — and benefit all parties concerned — by increasing patient safety through better education and other steps to improve the quality of medical care. The current debate has been sadly lacking in attention to the root causes of medical malpractice actions — medical errors.

From the landmark 1990 Harvard Medical Practice Study to the 1999 National Institute of Medicine report to a burgeoning number of others that echo the findings, the literature is now filled with documentation of preventable medical errors that, by some estimates, result in the death of almost 2,000 Missourians each year in hospitals alone and impose permanent disabilities on many more. The elderly are among the most vulnerable to such mishaps, and this effort could dovetail with the state's initiatives on improving nursing home care. Private accreditation authorities also have imposed new requirements on patient safety, including notification of errors to injured patients and their families.

Our system of ensuring patient safety may have grown accustomed to relying on medical malpractice judgments to compensate victims rather than taking often painful steps to eliminate unsafe practitioners and upgrade health-care delivery systems that breed preventable errors. Experience in other states and information on the National Practitioner Data Bank indicates that a small number of doctors – perhaps 5 or 6 percent – accounts for more than half of medical malpractice claims.

MDI recommends that the commission include representatives from the Missouri Department of Health and Senior Services, Missouri Board of Registration for the Healing Arts, Missouri Department of Insurance, Missouri State Medical Association, Missouri Association of Osteopathic Physicians and Surgeons, Missouri Academy of Family Physicians, the Missouri Hospital Association, the Missouri Health Care Association, the Missouri Association of Homes for the Aged, Missouri Nurses Association, the state's medical educators, other medical groups and consumers.

The commission should report back to the governor by Jan. 1, 2004 with recommendations for administrative and legislative action, including mandatory reporting of medical errors, public disclosure of medical errors and malpractice judgments, standards of care and any changes in licensing to protect health-care consumers.

Revisiting the *Scott* decision

Insurers and providers have been stirred by a recent court decision that one injury can have more than one non-economic damage cap applied, although it followed the findings of a federal court on a Missouri case several years before.

In *Scott v. SSM Healthcare* of January 2002, the Missouri Court of Appeals, Eastern District, countered most previous interpretations of the Missouri statutory cap on non-economic damages "per occurrence" set forth in Section 538.210, RSMo.

In *Scott*, a 17-year-old boy sustained serious permanent injuries as result of an undiagnosed sinus infection that spread to his brain.

The boy was involved in a car accident and was taken to the hospital where he was treated for minor injuries and released. Two days later, the boy returned to the hospital's emergency room, complaining of severe headaches. The boy received a CT scan of his head, and radiologist Dr. A concluded that the CT scan was normal. The boy was diagnosed with a mild concussion, presumably caused by the car accident, given headache medication and sent home. The next day the boy's condition did not improve, and the parents called the hospital to report continuing headaches, lethargy, nausea and vomiting. Emergency room physician Dr. B. advised them that these symptoms were further evidence of a concussion and should pass in a few days. The next morning, the boy collapsed in his kitchen, unable to use the right side of his body. He was rushed to a different hospital where a spinal tap and CT scan revealed a brain infection and swelling inside the skull. After several brain surgeries, the boy remained in a coma for several weeks. Despite considerable recovery, the boy sustained permanent injuries including "a significant degree" of paralysis on the right side of his body and a permanent drainage tube in his brain.

The boy and his mother filed suit against the hospital (both doctors were deemed agents of the hospital) alleging that Dr. A negligently misread the initial CT scan that would have permitted detection and treatment of the sinus infection before it spread to the brain and Dr. B negligently failed to instruct the parents to bring the boy back to the emergency room.

The jury found for the plaintiffs, and the trial court determined the boy was entitled to receive the statutory cap for two separate occurrences of malpractice. The hospital argued on appeal that because it was a single defendant, only one cap for noneconomic damages could apply to it. The court of appeals agreed with the trial court and determined that the only way to give meaning to the "per occurrence" language in the statute is to interpret Section 538.210.1 as applying a separate noneconomic damages cap to each separate, distinct negligent act by a defendant. The court held that the legislature otherwise would not have needed to place the "per occurrence" language in the statute.

In the *Scott* decision, the Missouri Eastern District Court of Appeals followed the 1996 federal court decision in *Romero v. U.S* that concluded two separate damage caps were appropriate when two separate, distinct "occurrences" of medical malpractice contributed to the plaintiff's injuries.[20]

The *Scott* decision has clearly caught the attention of doctors and insurers. Numerous doctors mentioned the decision in letters, telephone calls and e-mails to MDI. Insurers mentioned it

repeatedly in their responses to the MDI survey, and its ramifications were discussed at the October 30, 2002 public hearing.

The two concerns are that, first, the court decision violated the legislative intent of Section 538.210, RSMo, and, second, insurers have set their rates for years with the understanding that Missouri law permitted a single cap on non-economic damages per injured plaintiff, yet multiple caps may apply.

Whether the Missouri courts violated the intent of the General Assembly is often hard to determine. The official legislative history on bills is minimal, and the 197 members of the Senate and House may each have differing interpretations of a piece of legislation. The *Scott* court noted that the term "occurrence" was not defined in the statute itself, and that common dictionary definitions could plausibly refer to either the harm a plaintiff has sustained or to an act of medical negligence causing that harm.

Consistent with the *Scott* decision, the pre-legislative-session transcript of the meeting of stakeholders, including trial attorneys, hospitals, physicians and insurers in the medical malpractice debate from 1985, does refer to agreement on applying a cap. The representative speaking on behalf of the Missouri Association of Trial Attorneys (MATA) stated:

> The first area to be covered would deal with a cap on awards for non-economic loss. And I believe that we are in agreement that there would be no aggregate cap on awards for non-economic loss.[22]

The MATA representative then discussed the amount of the cap, the definitions of "defendant" and "health care providers," the exclusion of punitive damages from the cap and the need for a section to allow punitive damages only where willful or wanton conduct is shown. Afterwards, the other participants at the meeting agreed with the MATA characterization of the group's consensus

On the other hand, the standard definition within the insurance industry of an "occurrence" agrees with the losing argument advanced by the defendants in the *Scott* case. For example *Barron's Dictionary of Insurance Terms* (3rd. Ed.) defines an occurrence as:

> An event that results in bodily injury and/or property damage to a third party. A clause that is common to most liability insurance policies stipulates that all bodily injuries and/or property damages resulting from the same general conditions are interpreted as resulting from one occurrence and thus subject to the policy limits per occurrence.[23]

The insurance industry interprets the "per occurrence" language of Section 538.210 more akin to "per injury" than "per negligent act." A similar definition of "occurrence" can be found in medical malpractice policies used in Missouri. For example, the policy used by the Medical Protective Co. says an "occurrence" means

> "accident. All injuries arising from:
> a. the same or related acts, errors or omissions; or
> b. the continuous or repeated exposure to substantially the same harmful conditions will be considered one occurrence."

In terms of the availability and affordability of medical malpractice insurance in Missouri, the second concern regarding the *Scott* decision is perhaps more important: malpractice carriers are concerned that they priced coverage assuming that Section 538.210, RSMo provides a per-injury cap.[24] After *Scott*, that is clearly no longer appropriate in all situations. Yet, they cannot retroactively re-price their product. It is already typical for plaintiff's attorneys to sue multiple providers in a malpractice lawsuit; over the past 14 years, 56 percent of claims closed with payment had multiple defendants. The presumption is that plaintiffs' attorneys will begin to request multiple caps, increasing the average amount of claims, perhaps substantially.

In their testimony at the October 30, 2002 hearing, representatives of the Missouri Association of Trial Attorneys said they felt the *Scott* decision was a limited one, based on the facts of the case. One of the attorneys had taken three cases to verdicts since the decision without asking for multiple caps.

The *Scott* decision clearly does not underlie the rate increases that companies had already imposed. The Department of Insurance plans to ask the larger carriers whether they are seeing *Scott*-based requests for multiple caps on a regular basis in the future.

MDI recommends that the General Assembly revise Section 538.210 to preserve stability in the Missouri malpractice market. Predictability allows insurers to have greater confidence in their risk projections. Missouri's 1986 reforms have been tested by time and provide a substantial pool of loss data on their effect. Uncertainty because of *Scott* likely will encourage insurers to raise rates and keep them high for several years until the effect becomes clear.

From a legal and actuarial viewpoint, Scott may have only a slight effect on losses in Missouri. The MDI staff's review of the history of Missouri medical malpractice law, the federal precedent, the statute's background and the Scott case details found considerable underpinning for the decision, and two "occurrences" of medical malpractice appear to have taken place in the case.

On the other hand, insurers certainly view the case as added risk to Missouri's medical malpractice environment, which is helpful neither in keeping premiums reasonable nor in attracting new insurers to the market. The trial bar's use of Scott in crafting multiple caps in current court pleadings almost certainly will feed the insurers' perception.

If the General Assembly wishes to reverse the decision, it simply can delete "per occurrence."

Affidavit of merit

Proponents advocate strengthening Missouri's statutes requiring that the plaintiff file an affidavit of merit on the alleged act of malpractice. MDI has been advised by insurers that judges frequently do not dismiss the case if no such affidavit is filed.

The proposal would require 1) dismissal – without prejudice – if the affidavit is not filed within 90 days unless the court allows an extension and 2) the use of physicians for the affidavit who are licensed in the same discipline and actively practicing in the same field.

The medical affidavit was included in the 1986 reforms as a replacement for the professional liability review boards, which were established in 1976 as nonbinding screening mechanisms to reduce the filing of frivolous lawsuits. The boards were ruled unconstitutional in 1979. Yet **the affidavit process needs strengthening to fairly discourage the filing of lawsuits that lack merit.** Two-thirds of Missouri medical malpractice cases eventually are closed without any payment, and the ratio increases for claims against physicians.

The resources that private insurers are choosing to use to defend these cases – about $10,000 each for those claims with no award – have strained their financial underpinning. From 1997 to 1999, insurers' loss adjustment expenses – costs for defense attorneys, expert witnesses and the like – jumped from 15 percent to 41 percent of all medical malpractice premiums collected in the state. In 2001, the share still rested at 31 percent.

MDI sees the affidavit of merit as a potentially more valuable and far less objectionable means of reducing less meritorious lawsuits than other proposals, such as drastically reducing the cap on non-economic damages or contingency fee caps, *if* the language is crafted carefully.

But the available legislative draft, for example, would require a plaintiff's attorney to find a licensed nursing home or hospital to make such an affidavit if this type of facility is the defendant; no such licensee is likely to do so. The same probably would apply if the defendant was an ancillary provider, such as therapists typically employed by a facility. With the advent of managed care, such ancillary providers are more frequently the target of medical error cases. The requirement about a physician licensed in the same specialty/subspecialty as the doctor committing the alleged medical error may also represent too high a requirement in some areas with close-knit medical communities and seems unnecessarily onerous in cases of obvious errors (sponges or other foreign objects left in the body after surgery). The legislature may also wish to consider special circumstances in which multiple defendants are named because medical records are not available to identify the negligent party.

MDI agrees with the proposal that the court should be required to dismiss the case without an affidavit, unless an extension is granted, because lawsuits of suspect merit should not become mere bargaining chips for a settlement with the provider and the insurer.

Further restrictions on punitive damages

Proponents of tort change also have circulated heightened requirements for punitive damage awards, although by all accounts **these are rare in Missouri and are not covered by regular medical malpractice insurance**. Missouri already requires that the plaintiff prove the provider

engaged in "willful, wanton or malicious conduct" – a standard that only a tiny fraction of cases could meet.

The proposed change would require "clear and convincing" evidence – the highest civil standard – that the medical action was "outrageous because of the tortfeasor's (provider's) evil motive or reckless indifference to the rights of the plaintiff." Maximum damages would total twice the actual economic and non-economic damages awarded.

This provision, in effect, would eliminate punitive damages as a consequence for even the most flagrant cases of malpractice in Missouri.

Other statutory, administrative changes

Formal examination on medical malpractice ratemaking

MDI has scheduled a formal examination of leading medical malpractice insurers to answer growing questions about ratemaking.

First and foremost, the examination will determine **whether the medical malpractice market in Missouri is competitive**. Under Section 379.470, RSMo, MDI cannot reject rates on lines like medical malpractice unless 1) the rates are excessive or inadequate and 2) "a reasonable degree of competition does not exist."

This examination will focus on the physicians' portion of the market, which had as many as 32 companies reporting activity through the end of 2001; however, a fall 2002 MDI survey of carriers indicated that only three were still open to writing most new business -- i.e., for newly licensed doctors, physicians who lost their previous carrier and those who were shopping for better rates or service. Between the dearth of carriers and the implications of maintaining "tail" coverage, physicians have limited ability to change insurers in the current market and must absorb premium increases, regardless of size.

If the examination determines the market does not have "a reasonable degree of competition," **the MDI team will review whether rates for coverage are excessive, both overall and for individual specialties**. Over the past three years, medical malpractice carriers that dominate the Missouri market have raised rates by 25 to almost 100 percent. Anecdotal reports indicate rates for some doctors and subspecialties may have increased by even larger amounts. Doctors particularly are skeptical of the reasonableness of "tail" coverage that they buy to protect themselves when a "claims-made" policy expires.

The MDI team also will examine **how carriers calculate rates and the role Missouri loss experience plays in those calculations**. For example, during the 1990s, insurers' rates filed with MDI had little relationship to actual discounted charges to policyholders, according to survey results. MDI has received sharply differing reports from policyholders and companies on such issues as surcharges for adverse claims histories and pending claims. MDI's desk audits also have

failed to provide satisfactory determinations of how heavily Missouri's tort environment and insurers' experience have affected rate determinations, compared to national data. And MDI needs far more specific data on rates for specific subspecialties, such as obstetrics and neurosurgery, which are not now made available.

The examination also will review the amount, nature and use of insurers' spending for **loss adjustment expenses (LAE),** which in medical malpractice largely consists of defending against a claim that results in a lawsuit. In 1997, Missouri's medical malpractice insurers were spending 15.6 percent of premium on LAE, but that figure grew to 41.4 percent in 1999. In 2001, the spending still exceeded 31 percent of premium. Although medical malpractice has had historically higher spending levels on LAE than other lines because most claims entail lawsuits, such rapid growth and high spending has placed severe strains on the line's potential profitability.

As part of this examination, MDI also plans to determine how it can **better collect data to detect difficulties in the market and to identify problem areas**. Missouri is among the few states that collects and publishes data specific enough that policymakers have a broad understanding of trends for physicians versus medical malpractice in general. However, severe problems can exist with obstetricians and surgeons even though family practitioners largely escape those difficulties.

MDI also will consider making its recent survey of carriers an annual exercise, at least until the market stabilizes. Policymakers in state government need better insights into medical malpractice market dynamics, certainly as long as supply is severely limited and pricing is both high and volatile.

Elimination of mandatory insurance by law and contract

Missouri's 1986 law only requires physicians to carry medical malpractice insurance – a minimum of $500,000 – if they are on staff at a hospital in a county with at least 75,000 residents: St. Louis City and the urbanized counties of St. Louis, Clay, Boone, Buchanan, Franklin, Greene, Jasper, Jefferson and Jackson. Hospitals in smaller counties may require doctors on staff to carry such coverage, and HMOs since 1997 typically make physicians in their networks purchase coverage of $1 million per occurrence and $3 million maximum.

One draft legislative proposal would eliminate all legal and contractual provisions mandating coverage of physicians and, by implications, their staffs. They would have the freedom to carry lesser coverage or "go naked." Physicians with few if any personal assets would have few incentives to purchase a policy, denying patients that protection.

The prohibition on hospitals and health plans requiring coverage would transfer to those entities 100 percent of the cost of liability insurance for their operations. They, of course, likely would reduce compensation for physicians to cover those expenses. Doctors, in turn, would continue to be named as defendants in medical malpractice litigation, but almost certainly would have to hire their own legal defense out of pocket.

MDI believes that medical malpractice insurance provides necessary assurances for patients who are the subject of medical negligence and would oppose the repeal of Missouri's minimal requirements on medical malpractice coverage. The state's efforts are best focused on making such insurance more affordable and available for physicians and other health-care providers.

Medicaid reimbursements

MDI strongly recommends that, as soon as practical, Governor Holden consider adjustments to the state Medicaid reimbursement rates for obstetricians, who handle more than 40 percent of deliveries in Missouri under this program. As medical trade groups readily acknowledge, many of the current difficulties stem from the inability of doctors to pass through increased personal medical malpractice costs to HMOs, Medicare and Medicaid. Emergency room doctors, for example, are facing these expenses despite a reduction in Medicare reimbursements.

While doctors eventually can negotiate with managed care companies to raise reimbursement rates, obstetricians have no such ability under the Medicaid program. (Medicare is outside state control.) Despite the state's general revenue difficulties, it has a vested interest in making sure that Missouri's newborns have access to qualified physicians with insurance coverage, particularly in already underserved inner-city and rural areas.

Use of Missouri actuarial data for ratemaking

The law should explicitly allow MDI to reject filings that do not meet acceptable standards for relying on Missouri-only data in making rate calculations. The Insurance Services Office (ISO), relying on Missouri-only data except for trend, has advised smaller companies that rates for Missouri doctors should have been reduced for the past three years, despite large increases by other carriers.

Missouri could require the reporting of loss data to ISO, which now receives data for slightly more than one-third of the Missouri market, or MDI could otherwise appoint a statistical agent to collect and analyze Missouri data for use by insurers in setting rates.

Prohibition on surcharges for pending claims

Missouri, by law or regulation, should prohibit surcharging medical providers that have a pending medical malpractice claim/lawsuit. Two-thirds of medical malpractice claims do not result in payment. Many claims are filed that are a result of poor outcomes, not medical negligence or incompetence.

Most insurers advised MDI that they do not surcharge for such open claims, but carriers refuted that assertion. The disagreement may lie in nomenclature: most insurers appear to rely solely on discounts from base rates for "claims-free" records; doctors merely see that they are quoted a higher rate for having a pending claim and describe that as a "surcharge."

Barring any pricing differential would, if nothing else, provide reassurances to physicians.

MDI plans to investigate the use of these surcharges/discounts in the forthcoming examination of medical malpractice carriers.

Adequate notice to policyholders

MDI should seek statutory revisions that give physicians and other medical malpractice policyholders at least 60 days notice of nonrenewals and renewal rates. Unlike most policyholders in Missouri, medical malpractice insureds have no statutory protections that require adequate advance notice of nonrenewal and renewal rates.

Better monitoring of the market

MDI collects the most extensive state data in the country on medical malpractice insurance, and medical malpractice insurers -- including self-insured organizations -- are required to file specific data, such as claims information, with the agency. While many self-insureds comply with the law, others have been lackadaisical at best and defiant of their legal responsibilities at worst. MDI should have the power to fine self-insureds that do not report data as required by law.

Staggered policy expirations

MDI should work with insurers on breaking the logjam of policy expirations that now occur at the end of June and end of December for physicians to avoid any repetition of the "11th-hour quote" phenomenon that resulted this year. With the withdrawal of medical malpractice insurers, underwriters at the remaining carriers were unable to evaluate new applications, and too many physicians did not receive quotes on new policies until a few days or hours before their current contracts expired.

Footnotes

[1] Much of the material on the background of medical malpractice is drawn from the testimony of Lawrence Smarr, president of the Physician Insurers Association of America, before the U.S. House Judiciary Committee's subcommittee on civil and administrative law, June 12, 2002.

[2] *Black's Law Dictionary*. 6th ed. St. Paul, MN: West Publishing Co., 1991.

[3] "(T)he nature of both medical injuries and medical records makes it difficult for the patient to determine from his own resources whether a claim is valid. The malpractice system must thus rely heavily on discovery following filing of a claim (lawsuit) to determine whether there is evidence of actual negligence. Malpractice claims also generally name all parties involved in a patient's care (for example, the internist, surgeon, anesthetist, and hospital) in attempting to detect who the negligent party is. It is only through this discovery process that a plaintiff's attorney can judge whether it is worth investing resources to pursue the case further. The need for such a process implies, however, that there will be (many dropped rather quickly. Although dropped quickly, these cases inevitably impose some costs of defense, add to the administrative cost of the tort system, and lead to a perception of unfairness among doctors." "Reforming Medical Malpractice and Insurance," Joseph P. Newhouse and Paul C. Weiler, *Regulation: Cato Review of Business and Government,* Cato Institute, Washington, D.C.

Newhouse is the John D. and Catherine T. MacArthur Professor of Health Policy and Management at Harvard University and director of the Division of Health Policy Research and Education. Paul C. Weiler is a professor at Harvard Law School.

[4] The Missouri claims data does not include those involving PHICO in 2001. The Pennsylvania Department of Insurance took PHICO into rehabilitation (and later liquidation) in August 2001. The rehabilitators did not submit reports to MDI on claims closed and filed, and that information is not recoverable now. It is difficult to project the likely reports because PHICO had been rapidly losing its market share in Missouri over the previous two years; trending may have been unaffected because earlier years did not include PIE, another insolvent medical malpractice insurer. MDI expects to work with new management of the state's guaranty association, which is processing PHICO claims, to add information on these claims as they close.

Missouri law requires self-insured providers to report data on claims filed and closed in Section 383.105, RSMo. MDI staff have identified some providers who do not do so and has succeeded in gaining only partial compliance; one hospital system has refused. MDI does not have authority to fine violators. To the extent that providers have not been buying coverage in the admitted or surplus lines markets recently, the lack of such data does not affect trending.

[5] U.S. Department of Labor, Bureau of Labor Statistics.

[6] **Time Series Analysis of Cost Components of Medical Malpractice Awards, 1990-2001**

Variable	Parameter Estimate	Significance Level (P-Value)
Intercept	-1,33,803	.0001
CPI-Health Care, Lagged One Year	4,592	.0001
Missouri Average Annual Wages, Lagged One Year	32	.0001
Dummy Variable: Injury Severity Level 3 & 4	24,293	.0014
Dummy Variable: Injury Severity Level 5 & 6	104,212	.0001
Dummy Variable: Injury Severity Level 7 & 8	403,527	.0001
Dummy Variable: Injury Severity Level 9	126,998	.0001
Number of Years Since 1990	-66,834	.0001

All autocorrelative coefficients to the fourth order (not shown) are significant to the .0001 level.
Source: Missouri Department of Insurance medical malpractice claims data; Bureau of Labor Statistics Medical CPI for St. Louis and average annual wages for Missouri. Regression based on 6,694 claims close with payment, 1990-2001

[7] A portion of the decline in premiums can be accounted for by an increase in the market share of non-admitted writers, or the so-called surplus lines market that is not subject to state regulation. Based on calculations of NAIC annual statement data, the non-admitted market share of premiums earned increased from 10.9 percent to 18.6 percent between 1997 and 2001. (NAIC data on medical malpractice premiums for surplus lines companies is not readily available until 1997.) Medical malpractice premiums in the non-admitted market rose from $12.4 million in 1997 to $22.2 million in 2001; all of the increase occurred in 2000 and 2001. The data is not available on specialties, such as hospitals and physicians.

[8] The National Association of Insurance Commissioners, based in Kansas City, is composed of the insurance superintendents, directors and commissioners for all states, territories and the District of Columbia. It has an independent staff of analysts that produces multi-state data.

[9] St. Paul reportedly released $1.1 billion in over-reserves from 1992 to 1997. *Wall Street Journal*, June 24, 2002.

[10] Scpie is withdrawing from its national expansion program and retrenching to California-only business.

[11] In May 2002, the New Jersey Department of Banking and Insurance approved a plan for MIIX to discontinue its non-New Jersey business, close out its business in a state where it writes 37 percent of all doctors and open a successor company. The department indicated MIIX had enough to pay claims on current policies, and the plan – unlike an insolvency proceeding — avoids referral of new claims to the state's guaranty fund, which would only pay $300,000 per claim and subject individual doctors to paying the remainder of claims and defense costs.

[12] PHICO's 2000 market share is used because the Pennsylvania liquidators did not submit premium information for 2001.

[13] St. Paul's operations in Missouri had been highly profitable, with only a third of premium paid or reserved for losses. It had sought no rate increases here in recent years.

[14] Except for PHICO, which shows 2000 numbers. The Pennsylvania Department of Insurance's liquidators do not file required reports when insurers domiciled there become insolvent.

[15] These figures do not include cancellation of discounts.

[16] ISO has advised its member companies that it plans to file "loss-cost" increases of 13.3 percent for Missouri doctors and 14.3 percent for Missouri hospitals, effective April 1, 2003. It based its projections – which do not include loss adjustment and administrative expenses – on reports from companies with 36.7 percent of the Missouri market.

[17] *Kansas Malpractice Victims Coalition v. Bell*, 243 Kan. 333, 757 P.2d 251 (1988)

[18] In Nebraska, a $1.25 million cap on total medical malpractice awards, which had been in place since 1976, was ruled unconstitutional in June 2000 by a trial court that upheld a $5.6 million judgment for a baby's pre-birth injuries. The Nebraska Supreme Court is reviewing the case, *Gourley v. Nebraska Methodist Health System Inc.* In his ruling, the district court judge said that the cap was unconstitutional in that it creates two classes of malpractice victims: those with economic damages amounting to less than $1.25 million who can recover all their expenses and those who are more seriously injured who can only recover a portion. The constitution guarantees that everyone in a particular class be treated equally, he said. The judge also said that he could find no legitimate relationship between insurance and the cap. Insurance companies are only responsible for the first $200,000 of an award. The rest is paid from a state pool, the Hospital Medical Liability Excess Pool, which is funded by health care providers – generally known as a "patient compensation fund." The cap had been rarely reached. The case is being appealed to the state Supreme Court.

[19] Consortium is the legal right of one spouse to the company, affection and assistance of the other.

[20] *Romero v. U.S.*, 865 F.Supp. 585 (E.D. Mo. 1994), at page 593.

[21] Transcript of the November 27, 1985 meeting of the Missouri Association of Trial Attorneys, the Missouri Association of Osteopathic Physicians and Surgeons, the Missouri State Medical Association, the Missouri Hospital Association, the Missouri Professional Liability Insurance Association, the Providers Insurance Company, the Missouri Medical Insurance Company, Medical Defense Associates and the Professional Mutual Insurance Company, at page 4.

[22] *Barron's Dictionary of Insurance Terms*, Third Edition, 1995. See also the definition in the *Glossary of Insurance and Risk Management Terms* of the International Risk Management Institute, Inc., Sixth Edition, 1996.

[23] At this writing, MDI has not had the opportunity to query insurers on why such an assumption was realistic, given the contrary 1996 decision by the federal court in the *Romero v. U.S.* case.